

6-21-99 WR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND: #10A-F G772 PER INFORMANT G772 State of Maryland / Department of Health and Mental Hygiene

Amend #17, 19a, 5/26/99, BMW, Montg. Co.

Certificate of Death

Reg. No.

99 17501

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edward Aloysious McDermott, Sr.						2. Date of Death Month Day Year May 12, 1999		3. Time of Death 12:45pm	
	4a. Facility Name (If not institution, give street and number) 11115 Potomac Crest Drive						4b. City, Town, or Location of Death Potomac		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 484-09-1334		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) June 28, 1920		9. Birthplace (State or Foreign Country) Iowa	
	Usual Residence of Decedent									
10a. State FLORIDA		10b. County PALM BEACH		10c. City, Town or Location BOCA RATON				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 875 EAST CAMINO REAL 11115 Potomac Crest Drive		10f. Zip Code 33432		10g. Citizen of What Country? United States						
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Attorney				16b. Kind of Business/Industry Legal		
17. Father's Name (First, Middle, Last) Edward L. McDermott						18. Mother's Name (First, Middle, Maiden Surname) Sarah Larkin				
19a. Informant's Name/Relationship (Type, Print) Naola S. McDermott (Wife)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 875 EAST CAMINO REAL, BOCA RATON, FLORIDA 33432 11115 Potomac Crest Drive, Potomac, MD 20854				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State May 13, 99 Alexandria, Virginia				
21. Signature of Funeral Service Licensed 				22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Avenue, N.W. Washington, DC 20007						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Congestive heart failure</p> <p>b. Atherosclerotic heart disease</p> <p>c. </p> <p>d. </p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p>years</p> <p>years</p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>										
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.								23b. Did tobacco use contribute to the causa of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of causa of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Patricia L. Tomsko, MD				29c. License number DS1916				29d. Date signed (Month, Day, Year) May 13, 1999		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Patricia L. Tomsko MD, 11140 Rockville Pike, #348, Rockville, MD 20852										
31. Date filed (Month, Day, Year) MAY 18 1999				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

30

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17502

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Marian Agatha Perrizo McKay

2. Date of Death

Month Day Year

May 13, 1999

3. Time of Death

12:40 pm

4a. Facility Name (If not institution, give street and number)

6222 Rockhurst Road

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

469-12-6443

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 23, 1915

9. Birthplace (State or Foreign Country)

Minnesota

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6222 Rockhurst Road

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Mitchell Perrizo

18. Mother's Name (First, Middle, Maiden Surname)

Vidella O. Brouillard

19a. Informant's Name/Relationship (Type, Print)

John F. McKay/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8900 Lochaven Drive Gaithersburg, Maryland 20882

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

May 17, 1999

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

M00335

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/

Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue

Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Lung Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D20367

29d. Date signed (Month, Day, Year)

May 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joel P. Kalman, M.D. 6111 Executive Boulevard Rockville, Maryland 20852-3976

31. Date filed (Month, Day, Year)

MAY 18 1999

32. Registrar's Signature

Jennifer B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17503

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SARAH MONZEY

2. Date of Death

MAY 13, 1999

3. Time of Death

2:10AM

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

214-51-7747

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

Jan. 1, 1942

9. Birthplace (State or Foreign Country)

Liberia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10304 Ridgemoor Drive

10f. Zip Code

20901

10g. Citizen of What Country?

Liberia

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Jacob Conway

18. Mother's Name (First, Middle, Maiden Summa)

Darbo Gbey

19a. Informant's Name/Relationship (Type, Print)

Lewis Libiah Monzey (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as 10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

5-22-99

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

▶ *Ellen H. Rapp*

22. Name and Address of Facility

Rapp Funeral Services, P. A.

933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardio-pulmonary Failure

Due to (or as a consequence of):

b. Cerebro-vascular Accident

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d. Diabetes Mellitus

Approximate Interval Between Onset and Death

1 week

6 months

6 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ *Shelley Williams, MD*

29c. License number

D 44826

29d. Date signed (Month, Day, Year)

May 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shelley L. Williams, M. D., 2103 Hampshire Drive, Adelphi, MD 20783

31. Date filed (Month, Day, Year)

MAY 17 1999

32. Registrar's Signature

*B. Sparks*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17504

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

ELIZABETH ESTHER MURRAY

2. Date of Death
Month Day Year
MAY 14th, 1999

3. Time of Death
8:45 A.M.

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

5. Social Security Number

092-18-0133

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

APR. 21, 1924

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

3600 GLENEAGLES DRIVE, APT. #3B

10f. Zip Code

20906

10g. Citizen of What Country?

UNITED STATES OF AMERICA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOME MAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JAMES MALLOY

18. Mother's Name (First, Middle, Maiden Surname)

ESTHER KELLEY

19a. Informant's Name/Relationship (Type, Print)

ELIZABETH EVERHART (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

309 STONEGATE DRIVE SILVER SPRING MARYLAND 20905

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MARYLAND VETERANS CEMETERY-CROWNSVILLE

Date

MAY 18,

1999

20c. Location - City or Town, State

CROWNSVILLE MARYLAND

21. Signature of Funeral Service Licensee

John J. Schwartz

22. Name and Address of Facility

HINES-RINALDI FUNERAL HOME, INC.

11800 NEW HAMPSHIRE AVENUE

SILVER SPRING MARYLAND 20904-2891

23a. Permit. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Massive Cerebral Hemorrhage

Due to (or as a consequence of):

b. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

14 Hours

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation

2 ☐ Accident 6 ☐ Could not be determined

3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John J. Schwartz

29c. License number

208381

29d. Date signed (Month, Day, Year)

May 14, 1999

30. Name and address of person who completed cause of death (from 23a) (Type, Print)

Beth Ann Aventine, M.D. Leisure World Medical Center, S.S.M.D.

31. Date filed (Month, Day, Year)

MAY 17 1999

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Pharmaceutical Knowledge
Antibiotic Resistance

Antibiotic Resistance
Pharmaceutical Knowledge

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17505

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELBA OCCILEE MERRICK

2. Date of Death

Month Day Year
May 16, 1999

3. Time of Death

0250

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

219-74-8996

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 08 1939

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

926 Snow Hill Rd.

10f. Zip Code

21803

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

did not work

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

William T. Merrick

18. Mother's Name (First, Middle, Maiden Surname)

Elba May Stephens

19a. Informant's Name/Relationship (Type, Print)

Eugene L. Skinner - guardian

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5442 Tates Bank Rd., Cambridge MD 21613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dorchester Memorial Park 5-18-1999 Cambridge, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Kenneth R. Thomas Jr.

22. Name and Address of Facility

Thomas Funeral Home PA

700 Locust St. Cambridge MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

ASCVD

Due to (or as a consequence of):

b.

AORTIC STENOSIS

Due to (or as a consequence of):

c.

DOWNS SYNDROME

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

10 years

10 years

59 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

27a. Date of Injury

(Month, Day, Year)

27b. Time of Injury

M

27c. Injury at Work?

1 ☐ Yes 2 ☒ No

27d. Describe how injury occurred

27e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

27f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Abdul K. Garuba, Medical attending

29c. License number

D0046029

29d. Date signed (Month, Day, Year)

MAY 16 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ABDUL K. GARUBA MD 12137 ELM STREET, PRINCESS ANN MD.

31. Date filed (Month, Day, Year)

MAY 17 1999

32. Registrar's Signature

B. Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17506

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gladys Marie Moore

2. Date of Death

Month Day Year
May 11, 1999

3. Time of Death

10:00 AM

4a. Facility Name (If not institution, give street and number)

Dorchester General Hospital

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

213-12-5797

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug 5, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Wingate

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2113 Farm Creek Road

10f. Zip Code

21675

10g. Citizen of What Country?

US

11. Marital Status

☐ Never Married ☐ Married

☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Crab Picker

16b. Kind of Business/Industry

Seafood

17. Father's Name (First, Middle, Last)

Thomas Darius Bloodsworth

18. Mother's Name (First, Middle, Maiden Surname)

Phoebe Lewis

19a. Informant's Name/Relationship (Type, Print)

Edna N. Robinson Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2111 Farm Creek Road Wingate, Maryland 21675

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dorchester Memorial Park

Date

5/14/99

20c. Location - City or Town, State

Cambridge, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Thomas Funeral Home, P.A.

700 Locust Street Cambridge, Maryland 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Cerebro-vascular Accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus type II

Hypertension

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural

☐ Accident

☐ Suicide

☐ Homicide

☐ Pending investigation

☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury et Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

214349

29d. Date signed (Month, Day, Year)

5-11-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Eyup Tanman M.D.

15 Franklin St. Cambridge, MD 21613

31. Date filed (Month, Day, Year)

MAY 14 1999

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17507

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES WILSON NANCE				2. Date of Death Month Day Year MAY 11 1999		3. Time of Death 3:45PM	
	4a. Facility Name (If not institution, give street and number) National Institutes of Health Center				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 245-60-5610		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 22, 1921	9. Birthplace (State or Foreign Country) North Carolina
	Usual Residence of Decedent							
10a. State Virginia		10b. County Fairfax		10c. City, Town or Location McLean				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 7803 Foxhound Road				10f. Zip Code 22102		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Staff Director			16b. Kind of Business/Industry U.S. Senate Foreign Relations Comm.	
17. Father's Name (First, Middle, Last) James Nance				18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Monroe				
19a. Informant's Name/Relationship (Type, Print) Mary Lyda Nance/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7803 Foxhound Road, McLean, Va. 22102				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem.		Date 5/19/99		20c. Location - City or Town, State Arlington, Virginia		
21. Signature of Funeral Service Licensee Peter L. Hatfield				22. Name and Address of Facility MONEY & KING VIENNA FUNERAL HOME, INC. 171 W. Maple Ave., Vienna Va. 22180				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Resp failure due to pulm hemorrhage Due to (or as a consequence of): b. thrombocytopenia Due to (or as a consequence of): c. myelodysplastic Syndrome Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 3 hrs
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier MD		29c. License number MD 309 904 - E		29d. Date signed (Month, Day, Year) 5/12/99		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MICHAEL DE PIETRO MD 9000 ROCKVILLE PIKE, BETHESDA, MD 20892								
31. Date filed (Month, Day, Year) MAY 18 1999		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17508

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

John Nestor

2. Date of Death

May 13, 1999

3. Time of Death

1500 hrs

4a. Facility Name (If not institution, give street and number)

Duck Neck Campground

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

5. Social Security Number

098-03-6226

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 18, 1918

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

New Jersey

10b. County

Burlington

10c. City, Town or Location

Cinnaminson

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2616 New Albany Road

10f. Zip Code

08077

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WW II 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Heavy Equipment Operator

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Benjamin Nestor

18. Mother's Name (First, Middle, Maiden Surname)

Frances Horn

19a. Informant's Name/Relationship (Type, Print)

Frances Mary Johnston

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1718 Jefferson St., Cinnaminson, New Jersey 08077

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Cremation Center LLC/May 16,

Date

1999

20c. Location - City or Town, State

Chester, Maryland

21. Signature of Funeral Service Licensee

William L. King Jr.

22. Name and Address of Facility

Fellows, Helfenbein & Newman Funeral Home, P.A.

130 Speer Road, Chestertown, Maryland 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Myocardial Infarction

Approximate Interval Between Onset and Death

(IMMEDIATE)

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Prostate Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D00005754

29d. Date signed (Month, Day, Year)

5-15-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ralph E. Libby 204 Medical Center Road, Grasonville, MD 21638

31. Date filed (Month, Day, Year)

MAY 17 1999

32. Registrar's Signature

Beverly B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

MAY 17 1960
JAMES H. HARRIS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 17509

Amend #8,5/17/99,BMW, Montg.Co

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anna Belle Nelson				2. Date of Death Month May Day 11 Year 1999		3. Time of Death 9:25 P.M.	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 250-10-8134		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 21, 1921	9. Birthplace (State or Foreign Country) Georgia
	Usual Residence of Decedent							
10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 614 Sligo Avenue				10f. Zip Code 20910		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher			16b. Kind of Business/Industry Education	
17. Father's Name (First, Middle, Last) Isaac McDonald					18. Mother's Name (First, Middle, Maiden Surname) Lucille Tucker			
19a. Informant's Name/Relationship (Type, Print) William K. Nelson - Son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 52 Dykes Park Road Nanuet, New York 10954			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Rock Creek Cemetery		20c. Location - City or Town, State 5/15/99 Washington, D. C.		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Joseph Gawler's Sons 5130 WI Ave. NW Washington, D. C. 20016			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. exsanguination of aortic aneurysm Due to (or as a consequence of): b. Inhibition Due to (or as a consequence of): c. aortic aneurysm Due to (or as a consequence of): d. abdominal aneurysm.								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 					29c. License number D41162		29d. Date signed (Month, Day, Year) May 12 1999	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) V. Ganti 19519 Doctor Drive G'town MD 20674								
31. Date filed (Month, Day, Year) MAY 17 1999				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17510

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ethel Jean Niemann		2. Date of Death Month May Day 17 Year 1999		3. Time of Death 10:00 PM																		
	4a. Facility Name (If not Institution, give street and number) Genesis Eldercare Layhill Center		4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery																		
Funeral Director	5. Social Security Number 154 30 9051	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.																		
	8. Date of Birth (Month, Day, Year) October 3 1913		9. Birthplace (State or Foreign Country) Wisconsin																				
Usual Residence of Decedent																							
10a. State MD		10b. County Montgomery		10c. City, Town or Location Rockville																			
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 14643 Bauer Drive #211		10f. Zip Code 20853																			
10g. Citizen of What Country? United States		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:																			
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4																			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business/Industry Education																					
17. Father's Name (First, Middle, Last) Archie Harry Fessler			18. Mother's Name (First, Middle, Maiden Surname) Elsie Green																				
19a. Informant's Name/Relationship (Type, Print) Rolf Niemann/ Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 807 Norwood Road Silver Spring, MD 20905																				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory, or other place) Geo. Wash. University Medical Center		20c. Location - City or Town, State Washington, D.C.																			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037																					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																							
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>e.</td> <td>Empyema</td> <td rowspan="4">Approximate Interval Between Onset and Death 4 wks</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>f.</td> <td>Pneumonia</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="2">g.</td> <td></td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> <td></td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e.	Empyema	Approximate Interval Between Onset and Death 4 wks	Due to (or as a consequence of):		f.	Pneumonia	Due to (or as a consequence of):		g.				Due to (or as a consequence of):			
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e.	Empyema	Approximate Interval Between Onset and Death 4 wks																				
	Due to (or as a consequence of):																						
	f.	Pneumonia																					
	Due to (or as a consequence of):																						
g.																							
Due to (or as a consequence of):																							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M																			
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred																					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																							
29b. Signature and title of certifier 		29c. License number D38262		29d. Date signed (Month, Day, Year) May, 18, 1999																			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr Mendelivalt 2401 Research Blvd Suite 340 Rockville MD 20850																							
31. Date filed (Month, Day, Year) MAY 20 1999		32. Registrar's Signature 																					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17511

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Clarence Orem Jr.

2. Date of Death

May 18 1999

3. Time of Death

8:50 AM

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

215-38-0141

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 18, 1938

9. Birthplace (State or Foreign Country)

Chestertown, MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

Chestertown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8415 Rock Hall Road

10f. Zip Code

21620

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Shop Foreman

16b. Kind of Business/Industry

Heavy Construction

17. Father's Name (First, Middle, Last)

Clarence Dudley Orem, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Gardner

19a. Informant's Name/Relationship (Type, Print)

Marie Leiby Orem/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8415 Rock Hall Road, Chestertown, Maryland 21620

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Pauls Cemetery

Date

5/21/99

20c. Location - City or Town, State

Chestertown, Maryland

21. Signature of Funeral Service Licensee

Shirley B. Fellows

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.
130 Speer Road, Chestertown, Maryland 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Left Middle Cerebral Artery Ischemic Stroke

Approximate Interval Between Onset and Death

42 hours

Due to (or as a consequence of):

b. Atrial Fibrillation

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. J. H. Hays MD

29c. License number

AV4176435-149249

29d. Date signed (Month, Day, Year)

May 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dept. Neurology, UMMS, 22 S. Greene Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

Benjamin S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

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Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

11.2 - 2.5. 2. 19

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17512

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Cecelia Maria Ortloff

2. Date of Death

May 18, 1999

3. Time of Death

5:45 PM

4a. Facility Name (If not institution, give street and number)

7501 Democracy Boulevard, #113

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

218-26-8641

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 21, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7501 Democracy Boulevard, #113

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (13-16)
1-4 or 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

Retail Stores

17. Father's Name (First, Middle, Last)

William L. Ortloff, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Marie Tillie Ruoff

19a. Informant's Name/Relationship (Type, Print)

Phyllis E. Cromwell (executor)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7501 Democracy Boulevard, #113, Bethesda, MD 20817

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

5-19-99

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Oliver H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P.A.
933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Generalized Carcinomatosis

Due to (or as a consequence of):

1 month

b. Lung Cancer

Due to (or as a consequence of):

6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Cho Maung

29c. License number

D 45274

29d. Date signed (Month, Day, Year)

May 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cho Maung, M. D., 10810 Connecticut Avenue, Kensington, MD 20895

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17513

| | | | | | | | | |
|---|--|---|--|--|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Maggie Belle Overton | | | | 2. Date of Death
Month Day Year
May 14, 1999 | | 3. Time of Death
10:39 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Holy Cross Rehab Center | | | | 4b. City, Town, or Location of Death
Burtonsville | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
238-01-8851 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
87 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
May 7, 1912 | 9. Birthplace (State or Foreign Country)
Chowan, NC |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Olney | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
17315 Beulahar Road | | | | 10f. Zip Code
20832 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Nurse's Assistant | | | 16b. Kind of Business/Industry
Health Care | |
| 17. Father's Name (First, Middle, Last)
James Hall | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Maude Privott | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Barbara Rose - Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17315 Beulahar Road Olney, MD 20832 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Vine Oak Cemetery | | Date
5/19/99 | | 20c. Location - City or Town, State
Edenton, NC | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Metropolitan Funeral Service
5517 Vine Street Alexandria, VA 22310 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Aspiration pneumonia
Due to (or as a consequence of):
b. Parkinson's Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | | Approximate Interval Between Onset and Death
24°
10y- |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Emphysema | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D41931 | | 29d. Date signed (Month, Day, Year)
May 17, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. Shumacher MD 2309 Shorefield Rd. Wheaton MD 20902 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 18 1999 | | 32. Registrar's Signature
 | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17514

| | | | | | | | | | |
|---|---|---|--|---|---|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Anna Ottes Parks | | | | 2. Date of Death
Month Day Year
May 16, 1999 | | 3. Time of Death
3:40 PM | | |
| | 4a. Facility Name (If not Institution, give street and number)
3616 Littledale Road | | | | 4b. City, Town, or Location of Death
Kensington | | 4c. County of Death
Montgomery | | |
| Funeral
Director | 5. Social Security Number
577-09-0877 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
100 Yrs. | | 8. Date of Birth (Month, Day, Year)
November 12, 1898 | | |
| | 9. Birthplace (State or Foreign Country)
Michigan | | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Kensington | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
3616 Littledale Road | | 10f. Zip Code
20895 | | 10g. Citizen of What Country?
United States | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | 17. Father's Name (First, Middle, Last)
Anton Joseph Ottes | | 18. Mother's Name (First, Middle, Maiden Surname)
Barbara Rosa Gunkel | |
| 19a. Informant's Name/Relationship (Type, Print)
Jacqueline P. Alderson/Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8005 Kerry Lane, Chevy Chase, Maryland 20815 | | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery | | 20c. Date
May 20, 1999 | |
| 20d. Location - City or Town, State
Suitland, Maryland | | 21. Signature of Funeral Service Licensee
 MO1126 | | 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Head & Neck Cancer
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d. | | Approximate interval Between Onset and Death
2 years | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23c. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
MD 042783 | | 29d. Date signed (Month, Day, Year)
May 17, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Helene C. Freeman, M.D., 4910 Massachusetts Ave., NW Washington, D.C. 20016 | | 31. Date filed (Month, Day, Year)
MAY 18 1999 | | 32. Registrar's Signature
 | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17515

| | | | | | | | | |
|---|--|---|--|---|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Elizabeth Anne Paschall | | | | 2. Date of Death
Month 05 - Day 15 - Year 99 | | 3. Time of Death
0445 | |
| | 4a. Facility Name (If not institution, give street and number)
University of Maryland Medical System | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore City | |
| Funeral
Director | 5. Social Security Number
213-43-6613 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
4 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Oct. 10, 1994 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Calvert | | 10c. City, Town or Location
Dunkirk | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
11210 Oakwood Drive | | | | 10f. Zip Code
20754 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 0 College (1-4or 5+) | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
child | | | 16b. Kind of Business/Industry
none | |
| 17. Father's Name (First, Middle, Last)
Archie Lamarr Paschall, Jr. | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Carol Anne DeGast | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Archie Lamarr Paschall, Jr. (father) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
same as #10 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 5/20/1999 | | 20c. Location - City or Town, State
Brentwood, Maryland | | |
| 21. Signature of Funeral Service Licensee
Donald V. Borgwardt | | | | | 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 20705 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Fungal Septic Shock
Due to (or as a consequence of):
b. Acute Respiratory Distress Syndrome
Due to (or as a consequence of):
c. Staph Aureus Infective Endocarditis
Due to (or as a consequence of):
d. Cranio Facial Cardio-Cutaneous Syndrome | | | | | | | | Approximate Interval Between Onset and Death
72 hours
21 days
23 days
4 yrs |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
[Signature] | | | | 29c. License number
D40915 | | 29d. Date signed (Month, Day, Year)
5/15/99 | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
Theresa K. Sunderland, MD, 22 South Greene Street Rm 55D18 Baltimore Maryland 20201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 19 1999 | | | | 32. Registrar's Signature
[Signature] | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17516

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HERBERT GEORGE PERKINS

2. Date of Death

Month
MAYDay
14Year
1999

3. Time of Death

0219

Funeral
Director

4a. Facility Name (If not institution, give street and number)

9501 HOLSEY ROAD

4b. City, Town, or Location of Death

DAMASCUS

4c. County of Death

MONTGOMERY

5. Social Security Number

590-50-4705

6. Sex

☒ M ☐ F

7. Age (in yrs. last birthday)

62

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month

Day

Year

Jan. 20, 1937

9. Birthplace (State or Foreign Country)

Jamaica

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Damascus

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

9501 Holsey Road

10f. Zip Code

20872

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 yrs

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Cable Technician

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Harold Perkins

18. Mother's Name (First, Middle, Maiden Surname)

Phyllis Nash

19a. Informant's Name/Relationship (Type, Print)

Amanda Lyles (Friend)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9501 Holsey Rd., Damascus, MD 20872

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Friendship Church Cem. 5/20/99 Damascus, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24e. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certificate (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

(OME)

29c. License number

015236

29d. Date signed (Month, Day, Year)

MAY 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARL MARGOLIS, MD 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17517

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THEADORA S. PRATHER

2. Date of Death

Month Day Year
MAY 15, 1999

3. Time of Death

11:35 PM

4a. Facility Name (If not institution, give street and number)

Montgomery Village Care & Rehab Ct.

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

213-38-4400

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Mar. 19, 1937

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Germantown

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

25 Pickering Court, #201

10f. Zip Code

20874

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mail sorter

16b. Kind of Business/Industry

U.S. Post Office

17. Father's Name (First, Middle, Last)

Nathaniel Waters

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Duvall

19a. Informant's Name/Relationship (Type, Print)

Vicki Prather-Budd (Dau.)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12502 Lee Hill Dr., Monrovia, MD 21770

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Emory Grove Cem.

Date

5/21/99 Gaithersburg, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

15 MINS.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

10 years

c. Chronic Renal Failure

Due to (or as a consequence of):

10 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 43430

29d. Date signed (Month, Day, Year)

MAY 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GAURA NG THAKER, M.D 18111 PRINCE PHILIP DR #212 OLNEY MD 20832

State
Registrar

31. Date filed (Month, Day, Year)

MAY 18 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17518

| | | | | | | | | | | | | | | | |
|--|--|--|---|--|---|--|---|--|--|--|---|--|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Susan Janet Pratt | | | | 2. Date of Death
Month Day Year
May 15, 1999 | | | | 3. Time of Death
1:30 AM | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
4710 Bethesda Avenue, #1413 | | | | 4b. City, Town, or Location of Death
Bethesda | | | | 4c. County of Death
Montgomery | | | | | | |
| Funeral
Director | 5. Social Security Number
344-54-1571 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
39 Yrs. | | 8. Date of Birth (Month, Day, Year)
Aug. 4, 1959 | | 9. Birthplace (State or Foreign Country)
Pennsylvania | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Bethesda | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | |
| | 10e. Street and Number
4710 Bethesda Avenue, #1413 | | | | 10f. Zip Code
20814 | | 10g. Citizen of What Country?
United States | | | | | | | | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Billing Specialist | | | | 16b. Kind of Business/Industry
Law Firm | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Fredrick J. Pratt | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Nancy Daniels | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Carolyn N. Pratt (sister) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4710 Bethesda Avenue, #417, Bethesda, MD 20814 | | | | | | | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory | | 20c. Date
5-17-99 | | 20d. Location - City or Town, State
Beltsville, Maryland | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
Eileen H. Rapp | | | | 22. Name and Address of Facility
Rapp Funeral Services, P. A.
933 Gist Avenue, Silver Spring, MD 20910 | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. Cervical Cancer
Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. Pulmonary Metastasis
Due to (or as a consequence of):</td> </tr> <tr> <td>c. Respiratory Distress
Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Cervical Cancer
Due to (or as a consequence of): | Approximate Interval Between Onset and Death | b. Pulmonary Metastasis
Due to (or as a consequence of): | c. Respiratory Distress
Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Cervical Cancer
Due to (or as a consequence of): | Approximate Interval Between Onset and Death | | | | | | | | | | | | | |
| | b. Pulmonary Metastasis
Due to (or as a consequence of): | | | | | | | | | | | | | | |
| | c. Respiratory Distress
Due to (or as a consequence of): | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | | | | | | | | | | | | |
| 28a. Date of Injury (Month, Day Year) | | | | | | | | | | | | | | | |
| 28b. Time of Injury
M | | | | | | | | | | | | | | | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | |
| 28d. Describe how injury occurred | | | | | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
Paul MacKoul MD | | | | | | | | | | | | | | | |
| 29c. License number
MD 21318 | | | | | | | | | | | | | | | |
| 29d. Date signed (Month, Day, Year)
May 17, 1999 | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul MacKoul, M. D., 110 Irving Street, NW, #C-2149, Washington, DC 20010 | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 18 1999 | | | | | | | | | | | | | | | |
| 32. Registrar's Signature
B. Sparks | | | | | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17519

| | | | | | | | | | |
|---|--|---------------------------|---|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Gloria Monzella Repass | | | | | 2. Date of Death
Month Day Year
May 19, 1999 | | 3. Time of Death
12:25pm | |
| | 4a. Facility Name (If not institution, give street and number)
19515 Frederick Road Lot 147 | | | | | 4b. City, Town, or Location of Death
Germantown | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
216-64-3590 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
68 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
April 24, 1931 | | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
Md. | | 10b. County
Montgomery | | 10c. City, Town or Location
Germantown | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
19515 Frederick Rd. Lot 147 | | | | | 10f. Zip Code
20876 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Own Home | | | |
| 17. Father's Name (First, Middle, Last)
Armiflead Mock | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Ellen Fisher | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Patty Parsons (Daughter) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
19515 Frederick Rd. Lot 147 Germantown, Md. 20876 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery | | Date
May 22, 1999 | | 20c. Location - City or Town, State
Silver Spring, Md. | | |
| 21. Signature of Funeral Service Licensee
Curtis E. Day | | | | | 22. Name and Address of Facility
DeVol Funeral Home
10 East Deer Park Dr. Gaithersburg, Md. 20877 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive Heart Failure
Due to (or as a consequence of):
Chronic Obstructive Pulmonary Disease
Due to (or as a consequence of):
Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Diabetes Mellitis
Hypertension
B. Asthma | | | | | | | | | Approximate Interval Between Onset and Death
1 Year
10 Years + |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitis
Hypertension
B. Asthma | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier
Manbir Takhar | | 29c. License number
D46747 | | 29d. Date signed (Month, Day, Year)
May 20, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Manbir Takhar M.D. 19504 Amaranth Drive Germantown, Md. 20874 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 21 1999 | | | 32. Registrar's Signature
B. Sparks | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17520

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn W. Parks

2. Date of Death

Month Day Year
May 13, 1999

3. Time of Death

8:30 p.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Edw.W.McCready Memorial Hospital

4b. City, Town, or Location of Death

Crisfield

4c. County of Death

Somerset

5. Social Security Number

218-34-9073

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 19, 1915

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Virginia

10b. County

Accomack

10c. City, Town or Location

Tangier

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

16418 West Ridge Road

10f. Zip Code

23440

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8College (1-4 or 5+)
016a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

At Home

17. Father's Name (First, Middle, Last)

John P. Williams

18. Mother's Name (First, Middle, Maiden Surname)

Rose Ellen Pruitt

19a. Informant's Name/Relationship (Type, Print)

Stewart W. Parks (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16538 West Ridge Road-PO Box 210-Tangier, VA 23440

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Swain Memorial Cemetery

Date

5/18/99

20c. Location - City or Town, State

Tangier, VA

21. Signature of Funeral Service Licensee

Robert H. Bradshaw

22. Name and Address of Facility

Bradshaw & Sons Funeral Home

306 W. Main St. - Crisfield, MD 21817

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Pneumonia
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Dr. Vijay Karumbunathan

29c. License number

D48098

29d. Date signed (Month, Day, Year)

5-13-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Vijay Karumbunathan, 201 Hall Highway, Crisfield, Md. 21817

31. Date filed (Month, Day, Year)

MAY 18 1999

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17521

| | | | | | | | | | | | | | | | | | | | | |
|---|---|------------------------|---|---|--|--------------------------|---|--|--|---|----|------------------------|----------------------------------|--|----|--|----|--|----|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LILLIAN ARRINGTON PARROTT | | | | 2. Date of Death
Month Day Year
May 10 1999 | | | | 3. Time of Death
4:12 a | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
The Memorial Hospital | | | | 4b. City, Town, or Location of Death
Easton | | | | 4c. County of Death
Talbot | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
217-14-0001 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
82 Yrs. | | 8. Date of Birth (Month, Day, Year)
NOV. 6, 1916 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | |
| 10a. State
MD | | 10b. County
TALBOT | | 10c. City, Town or Location
OXFORD | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | |
| 10e. Street and Number
5260 OXFORD ROAD | | | | 10f. Zip Code
21654 | | | | 10g. Citizen of What Country?
USA | | | | | | | | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4or 5+) -0- | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | | | 16b. Kind of Business/Industry
OWN HOME | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
W. WALTER ARRINGTON | | | | 18. Mother's Name (First, Middle, Maiden Surname)
LILLIE MARSHALL | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
ISAAC T. PARROTT /HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5260 OXFORD ROAD, OXFORD, MD 21654 | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
OXFORD CEMETERY | | Date
5-14-99 | | 20c. Location - City or Town, State
OXFORD, MD | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
Joseph M. Ostrowski | | | | 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 S. HARRISON ST., EASTON, MD 21601 | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Intracerebral Hematoma</td> <td rowspan="4"> Due to (or as a consequence of): </td> <td rowspan="4"> Approximate Interval Between Onset and Death
4 days </td> </tr> <tr><td>b.</td><td></td></tr> <tr><td>c.</td><td></td></tr> <tr><td>d.</td><td></td></tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Intracerebral Hematoma | Due to (or as a consequence of): | Approximate Interval Between Onset and Death
4 days | b. | | c. | | d. | |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Intracerebral Hematoma | Due to (or as a consequence of): | Approximate Interval Between Onset and Death
4 days | | | | | | | | | | | | | | | | |
| | b. | | | | | | | | | | | | | | | | | | | |
| | c. | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | |
| | | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
Dennis M. Deshield | | | | 29c. License number
D0053110 | | | | | | | | | | | | |
| | | | | 29d. Date signed (Month, Day, Year)
5/10/99 | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DENNIS DESHIELD, M.D., 219 SOUTH WASHINGTON ST., EASTON, MD 21601 | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 11 1999 | | | | 32. Registrar's Signature
Dennis M. Deshield | | | | | | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17522

Physician
/Medical
Examiner

Funeral
Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

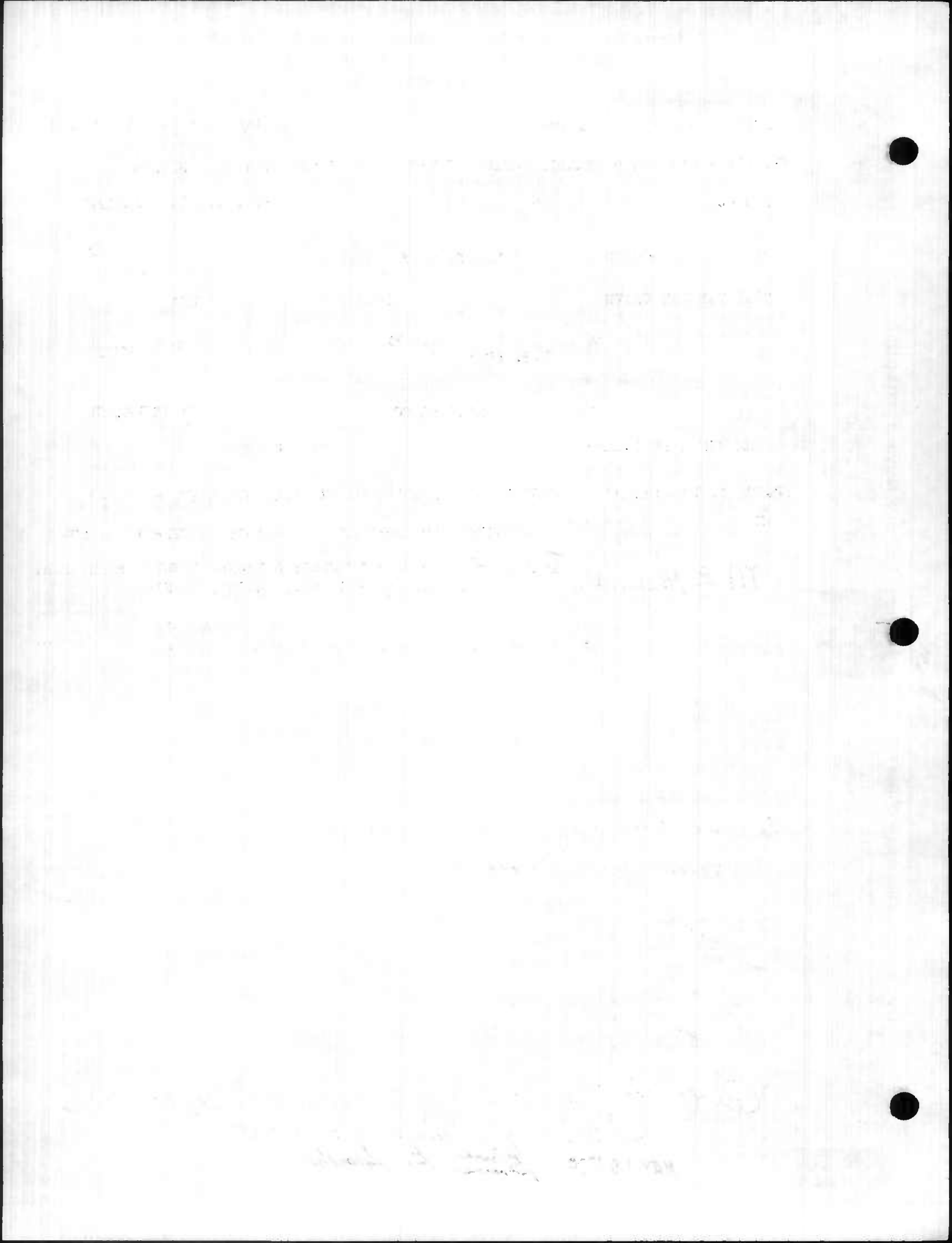
| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
JOHN WILLIE PRITCHARD | | | | 2. Date of Death
Month MAY Day 18 Year 1999 | | 3. Time of Death
11:00 AM | |
| 4a. Facility Name (If not institution, give street and number)
ST. AGNES NURSING & REHABILITATION CENTER | | | | 4b. City, Town, or Location of Death
ELLICOTT CITY | | 4c. County of Death
HOWARD | |
| 5. Social Security Number
213-01-8226 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (in yrs. last birthday)
84 Yrs. | | 8. Date of Birth (Month, Day, Year)
SEPT. 1, 1914 | |
| 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MD | | 10b. County
HOWARD | | 10c. City, Town or Location
ELLICOTT CITY | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
9401 PARSLEY DRIVE | | 10f. Zip Code
21042 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates
U.S. ARMY | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify:
WHITE | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
11 | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SALESPERSON | | 16b. Kind of Business/Industry
LIFE INSURANCE | | 17. Father's Name (First, Middle, Last)
JOHN HENRY PRITCHARD | |
| 18. Mother's Name (First, Middle, Maiden Surname)
LOUISA CRAFT | | 19a. Informant's Name/Relationship (Type, Print)
SHARON P. WILLIAMSON / DAUGHTER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9401 PARSLEY DRIVE, ELLICOTT CITY, MD 21042 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHESTERFIELD CEMETERY | | 20c. Date
5-21-99 | | 20d. Location - City or Town, State
CENTREVILLE, MD | | 21. Signature of Funeral Service Licensee
M. E. Newman III CFSP | |
| 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 S. HARRISON ST., EASTON, MD 21601 | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. END STAGE Emphysema WITH RESPIRATORY 5 YEARS
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 23c. Were an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 23d. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SEVERE CORONARY HEART DISEASE
MULTI-INFARCT DEMENTIA | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. Signature and title of certifier
Attending | | 29c. License number
D16200 | | 29d. Date signed (Month, Day, Year)
MAY 18, 1999 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
720 C MAIDEN CHOICE LANE BALTO, MD 21228 | |
| 31. Date filed (Month, Day, Year)
MAY 19 1999 | | 32. Registrar's Signature
B. Sparks | | 33. Registrar's Title | | 34. Registrar's Office | |



99-2832-043

BRANDON T. RHODES

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ASP ITEMS: #23 PART I, 27 PER MEO G772 6-16-99 WR. Certificate of Death

Reg. No. 99-17523

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | | | |
|---|--|---|--|--|--|---|---|---|--|--|--|
| Physician /Medical Examiner | | 1. Decedent's Name (First, Middle, Last)
BRANDON TRAVIS RHODES | | | | 2. Date of Death
Month Day Year
MAY 16 1999 | | 3. Time of Death
0657 | | | |
| Funeral Director | | 4a. Facility Name (If not institution, give street and number)
WASHINGTON COUNTY HOSPITAL | | | 4b. City, Town, or Location of Death
HAGERSTOWN | | 4c. County of Death
WASHINGTON | | | | |
| 5. Social Security Number
213-55-9573 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
Yrs. Months Days
29 | | 8. Date of Birth (Month, Day, Year)
April 17, 1999 | | 9. Birthplace (State or Foreign Country)
Maryland | | | |
| Usual Residence of Decedent | | 10a. State
Maryland | | | 10b. County
Washington | | 10c. City, Town or Location
Sharpsburg | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
5003 Churchey Road | | | | 10f. Zip Code
21782 | | 10g. Citizen of What Country?
U.S.A. | | | | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 0 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Never Employed | | | 16b. Kind of Business/Industry
None | | | | |
| 17. Father's Name (First, Middle, Last)
Randy Lee Rhodes | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sarah Kathleen Giffin | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Randy Lee Rhodes, Father | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. BOX 386, Sharpsburg, Maryland 21782 | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenlawn Memorial Park | | | 20c. Location - City or Town, State
05/22/1999 Williamsport, MD | | | | | |
| 21. Signature of Funeral Service Licensee
P. Steven Danfelt, Jr. | | | | | 22. Name and Address of Facility
7606 Old National Pike
East Funeral Home Boonsboro, Maryland 21713 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. SUDDEN INFANT DEATH SYNDROME
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed?
1 Yes 2 No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | | | |
| 25. Was case referred to medical examiner?
1 Yes 2 No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
Stephen S. Radentz, MD | | | | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
MAY 17, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)
Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| State Registrar | | 31. Date filed (Month, Day, Year)
MAY 24 1999 | | 32. Registrar's Signature
B. Sparks | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17526

| | | | | | | | | |
|--|---|--|---|--|--|--------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Emma Rose Rightnour | | | | 2. Date of Death
Month 05 Day 15 Year 99 | | 3. Time of Death
10:15AM | |
| | 4a. Facility Name (If not institution, give street and number)
Homewood at Williamsport | | | | 4b. City, Town, or Location of Death
Williamsport | | 4c. County of Death
Washington County | |
| Funeral
Director | 5. Social Security Number
205-16-3479 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
83 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sept. 28, 1915 | 9. Birthplace (State or Foreign Country)
Columbe, SD |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
WA | | 10b. County
Morgan County | | 10c. City, Town or Location
Berkley Springs | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
602 Harrison Avenue | | | | 10f. Zip Code
85411 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (12) 5+ College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Educator | | 16b. Kind of Business/Industry
Education | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Wiley Thomas Rightnour | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Bertha Lahr | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Wales E. Rightnour, brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4159 Centergate Blvd. Sarasota, Fla. | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evergreen Cemetery | | Date
5-19-99 | | 20c. Location - City or Town, State
Gettysburg, Pa. 17325 | |
| | 21. Signature of Funeral Service Licensee
Dennis L. Davis | | 22. Name and Address of Facility
Davis Funeral Home
Pennsylvania Avenue Smithsburg, Maryland 21783 | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div> <p>a. Cerebrovascular accident
Due to (or as a consequence of):</p> <p>b. Diabetes
Due to (or as a consequence of):</p> <p>c. Dementia
Due to (or as a consequence of):</p> <p>d. Coronary artery disease</p> </div> <div> <p>Approximate interval between Onset and Death</p> <p>24 hrs</p> <p>Years</p> <p>Years</p> <p>Years</p> </div> </div> | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| State
Registrar | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
Dennis L. Davis MD | | | | 29c. License number
D0047234 | | 29d. Date signed (Month, Day, Year)
5/15/99 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kelli A Strauss MD 747 Northern Ave Hagerstown MD 21742 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 21 1999 | | | | 32. Registrar's Signature
B. Sparks | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99-17525

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | | | |
|--|--|---|--|---|--------------------------------|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)
BORIS ROZOV | | | | 2. Date of Death
Month Day Year
MAY 15, 1999 | | | | 3. Time of Death
2:58PM | |
| 4a. Facility Name (If not institution, give street and number)
HEBREW HOME OF GREATER WASHINGTON | | | | 4b. City, Town, or Location of Death
ROCKVILLE | | | | 4c. County of Death
MONTGOMERY | |
| 5. Social Security Number
127-78-9231 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
71 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
AUG. 5, 1927 | | 9. Birthplace (State or Foreign Country)
UKRAINE | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
MONTGOMERY | | 10c. City, Town or Location
KENSINGTON | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
10920 CONNECTICUT AVENUE #426 | | | | 10f. Zip Code
20895 | | 10g. Citizen of What Country?
UNITED STATES | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MECHANICAL ENGINEER | | | 16b. Kind of Business/Industry
RUSSIAN GOVERNMENT | | |
| 17. Father's Name (First, Middle, Last)
LEV ROZOV | | | | 18. Mother's Name (First, Middle, Maiden Surname)
IDA SAKOVSKY | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
MINNA ROZOV (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10920 CONNECTICUT AVE. #426-KENSINGTON, MD. 20895 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
JUDEAN MEMORIAL GARDENS | | Date
5/17/99 | | 20c. Location - City or Town, State
OLNEY, MARYLAND | |
| 21. Signature of Funeral Service Licensee
Donald C. Stettin | | | | 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. SMALL CELL CARCINOMA OF LUNG
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

— | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
Donald C. Stettin M.D. | | | | 29c. License number
D 18084 | | | 29d. Date signed (Month, Day, Year)
MAY 16, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
D. D. PATEL M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1999 | | | | 32. Registrar's Signature
B. Sparks | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

3

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17526

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET V. RIGDON

2. Date of Death

May 8, 1999

3. Time of Death

2:45 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

26794 Johnson Creek Road (residence)

4b. City, Town, or Location of Death

Crisfield

4c. County of Death

Somerset

5. Social Security Number

499-18-2570

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 24, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Somerset

10c. City, Town or Location

Crisfield

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

26794 Johnson Creek Road

10f. Zip Code

21817

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Howard I. Reed

18. Mother's Name (First, Middle, Maiden Surname)

Ida Coleman

19a. Informant's Name/Relationship (Type, Print)

Thomas E. Rigdon, Jr. (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6517 Carlinda Ave. - Columbia, MD 21046

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Salisbury Crematory

Date

5/10/99

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

Robert H. Bradshaw

22. Name and Address of Facility

Bradshaw & Sons Funeral Home
306 W. Main St. - Crisfield, MD 21817

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Minutes

Due to (or as a consequence of):

b. ASCVD

Months

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 51086

29d. Date signed (Month, Day, Year)

May 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. Kanchana, M.D. - 320 W. Main St. - Crisfield, MD 21817

31. Date filed (Month, Day, Year)

MAY 12 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

cm
 Jimmy
 Laverne Reed

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, 27, 28A-F PER MEO G772 6-7-99 WR.

Certificate of Death

Reg. No.

99 17527

| | | | | | | | | | | |
|--|---|--|---|--|--|---|--|--|---------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Jimmy Leavern Reed | | | | 2. Date of Death
Month Day Year
May 16, 1999 | | 3. Time of Death
9:54 P.M. | | | |
| | 4e. Facility Name (If not institution, give street and number)
Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | | | |
| Funeral
Director | 5. Social Security Number
219-04-3380 | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
33 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Nov. 29, 1965 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Queen Annes | | 10c. City, Town or Location
Queenstown | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
801 Arrington Road | | | | 10f. Zip Code
21617 | | 10g. Citizen of What Country?
USA | | | | |
| 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Service Attendant | | | 16b. Kind of Business/Industry
Exxon Service Station | | | |
| 17. Father's Name (First, Middle, Last)
Richard L. Keene | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Shirley A. Reed | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Richard Keene (father) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
801 Arrington Rd., Queenstown, Maryland 21617 | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Carmichael Cemetery | | Date
5/21/99 | | 20c. Location - City or Town, State
Carmichael, Maryland | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Bennie Smith Funeral Home
P.O. Box 1687, Easton, Maryland 21601 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. COCAINE INTOXICATION
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | Approximate interval Between Onset and Death | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input checked="" type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
Found: 5-16-99 | | 28b. Time of Injury
Found: 8:30 P M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
UNKNOWN | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
FOUND IN AUTO | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
1515 POSTAL ROAD, CHESTER, QUEEN ANNE'S CO., MD. | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | | | | | | 29c. License number
O.C.M.E. | |
| | | 29d. Date signed (Month, Day, Year)
May 18, 1999 | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Joseph Pastanor 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 19 1999 | | 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17528

| | | | | | | | |
|--|---|--|---|--------------------------------|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
William Elmer Stevens | | | | 2. Date of Death
Month Day Year
May 17 1999 | | 3. Time of Death
15:55 |
| | 4a. Facility Name (If not institution, give street and number)
11403 Stonecroft Court, Apt. 104A | | | | 4b. City, Town, or Location of Death
Hagerstown | | 4c. County of Death
Washington County |
| Funeral
Director | 5. Social Security Number
220-28-4158 | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
64 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
July 4, 1934 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Washington Co. | 10c. City, Town or Location
Hagerstown | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
11403 Stonecroft Court, Apt. 104A | | | 10f. Zip Code
21742 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 College (1-4or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Plumber | | 16b. Kind of Business/Industry
Plumbing Contractor | | |
| | 17. Father's Name (First, Middle, Last)
Owen E. Stevens | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Viola Clopper | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Gerald L. Stevens/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
202A Tiffany Drive, Waynesboro, Virginia 22980 | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Lawn Memorial Park | | Date
May 20 | 20c. Location - City or Town, State
Hagerstown, Maryland | |
| | 21. Signature of Funeral Service Licensee
<i>Douglas A. Fiery</i> | | | | 22. Name and Address of Facility
Douglas A. Fiery Funeral Home
1331 Eastern Blvd., N., Hagerstown, Maryland 21742 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. <i>Hypertensive heart disease</i>
Due to (or as a consequence of):
b. <i>Arterial hypertension</i>
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death
years
13 |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Chronic Atrial Fibrillation</i>
<i>Diabetes Mellitus</i> | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| State Registrar | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | |
| | 29b. Signature and title of certifier
<i>William E. Stevens MD</i> | | 29c. License number
D41786 | | 29d. Date signed (Month, Day, Year)
5/19/99 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<i>J. Allen Cherry MD 12821 Oak Hill Ave Hagerstown MD 21742</i> | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 20 1999 | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17529

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BETTY LOU SCHWANEBECK

2. Date of Death

May 14, 1999

3. Time of Death

2120

4a. Facility Name (If not institution, give street and number)

WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

Funeral
Director

5. Social Security Number

220-32-5434

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

DEC. 28, 1933

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WASHINGTON

10c. City, Town or Location

BOONSBORO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

141 SOUTH MAIN STREET

10f. Zip Code

21713

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Navar Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

Collega (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

WAITRESS

16b. Kind of Business/Industry

RESTAURANT

17. Father's Name (First, Middle, Last)

EZEKIEL TESTERMAN

18. Mother's Name (First, Middle, Maiden Surname)

INEZ BLADEN

19a. Informant's Name/Relationship (Type, Print)

JOANNE KEYSER/NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21417 KEADLE ROAD, BOONSBORO, MARYLAND 21713

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

RESTHAVEN MEM, GARDENS

Date

5/18/99

20c. Location - City or Town, State

FREDERICK, MARYLAND

21. Signature of Funeral Service Licensee

Paul M. Dean

Paul M. Dean

22. Name and Address of Facility

BAST FUNERAL HOME

7606 Old National Pike

Boonsboro, Maryland 21713

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. STROKE

Due to (or as a consequence of):

b. ARTERIO SCLEROSIS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

ONE WEEK

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEIZURE DISORDER

BREAST CANCER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ OOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Paul M. Dean

29c. License number

D44996

29d. Date signed (Month, Day, Year)

May 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZAFAR MAJID MD 20311 LAPPANS RD BOONSBORO MD 21713

31. Date filed (Month, Day, Year)

MAY 17 1999

32. Registrar's Signature

Paul M. Dean

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #1,10e, 20b, cwc,5/24/99, Kent Co.

Certificate of Death

Reg. No.

99 17530

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
Nellie Augusta Storms | | | | 2. Date of Death
Month May Day 20 Year 1999 | | | | 3. Time of Death
3:30p.m. | | | |
| 4a. Facility Name (If not institution, give street and number)
104 Berry Court (Residence) | | | | | | 4b. City, Town, or Location of Death
Chestertown | | | | 4c. County of Death
Queen Anne's | |
| 5. Social Security Number
171-10-2346 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
93 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | 6. Date of Birth (Month, Day, Year)
April 29, 1906 | |
| 9. Birthplace (State or Foreign Country)
Illinois | | | | | | | | | | | |
| Usual Residence of Decedent | | | | 10a. State
Maryland | | | | 10b. County
Queen Anne's | | | |
| 10c. City, Town or Location
Chestertown | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 10e. Street and Number
104 Berry Court | | | | 10f. Zip Code
21620 | | | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) | | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | |
| 16b. Kind of Business/Industry
Ownhome | | | | 17. Father's Name (First, Middle, Last)
John V. Williams | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sally Patterson Davis | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Shirley Sutton/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
104 Berry Court, Chestertown, MD 21620 | | | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Odd Fellows Cemetery | | | | Date
5/22/99 | | 20c. Location - City or Town, State
Seaford, DE | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home, P.A.
130 Speer Road, Chestertown, Maryland 21620 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Myocardial Infarction
Due to (or as a consequence of):
A-S-I-D
Due to (or as a consequence of):
Due to (or as a consequence of):
Due to (or as a consequence of): | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Non insulin diabetes mellitus
High blood pressure | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D16488 | | | | 29d. Date signed (Month, Day, Year)
5/21/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wayne D. Benjamin, MD, Chestertown, MD | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 21 1999 | | | | 32. Registrar's Signature
 | | | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Handwritten signature and date: 1951

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend #7, 5/19/99, BMW, Montg. Co.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17531

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JIMMIE G. SCOTT

2. Date of Death

MAY 14, 1999

3. Time of Death

1340

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

579-54-5062

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57 ~~58~~ Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

DEC. 21, 1941

9. Birthplace (State or Foreign Country)

N. CAROLINA

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGES

10c. City, Town or Location

LANDOVER

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

7453 VILLAGE GREEN TERRACE

10f. Zip Code

20785

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 YEARS

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BOILER PLANT OPERATOR

16b. Kind of Business/Industry

ST. ELIZABETH

17. Father's Name (First, Middle, Last)

JIM SCOTT

18. Mother's Name (First, Middle, Maiden Surname)

WILLIE L. BUSSEY

19a. Informant's Name/Relationship (Type, Print)

BETSY R. SCOTT (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7453 VILLAGE GREEN TERR, LANDOVER, MD. 20785

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METROPOLITAN CREMATORY

Date

5/20/99

20c. Location - City or Town, State

ALEXANDRIA, VIRGINIA

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

AUSTIN ROYSTER FUNERAL HOME
3821 14TH ST. N.W., WASH, DC. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. cardiopulmonary arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acute Myocardial Infarction

Due to (or as a consequence of):

c. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

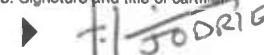
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D40324

29d. Date signed (Month, Day, Year)

5/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TERRY A. JODRIE, M.D. 3001 HOSPITAL DRIVE, CHEVERLY, MD 20785

State
Registrar

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-17532

| | | | | | | | | |
|--|--|---|--|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
James Philip Shambaugh | | | | 2. Date of Death
Month May Day 13 Year 1999 | | 3. Time of Death
5:30 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
8100 Connecticut Avenue #1404 | | | | 4b. City, Town, or Location of Death
Chevy Chase | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
137-18-5369 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
84 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 16, 1914 | |
| | 9. Birthplace (State or Foreign Country)
China | | 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Chevy Chase | |
| 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
8100 Connecticut Avenue | | 10f. Zip Code
20815 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Chemical Engineer | | 16b. Kind of Business/Industry
Petroleum | | | | |
| 17. Father's Name (First, Middle, Last)
William Ira Shambaugh | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Mundis | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
James P. Shambaugh, Jr. - Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2830 Upton St. N.W. Washington, D. C. 20008 | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
National Crematory | | Date
5/17/99 | | 20c. Location - City or Town, State
Falls Church, VA | | |
| 21. Signature of Funeral Service Licensee
<i>Loek M. Peters</i> | | | | 22. Name and Address of Facility
Joseph Gawler's Sons
5130 WI Ave. NW Washington, D. C. 20016 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Multiple Pulmonary Infarcts
Due to (or as a consequence of):

b. Multiple Pulmonary Emboli
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Aortic Valve Replacement | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Jessica L. Dodge, M.D.</i> | | | | 29c. License number
RES-000 | | 29d. Date signed (Month, Day, Year)
May 13, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jessica L. Dodge, M. D. 600 N. Wolfe Street Baltimore, Maryland 21287 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 18 1999 | | | | 32. Registrar's Signature
<i>B. Sparks</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17533

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Annabelle H. Sharkey

2. Date of Death

Month
MayDay
14,Year
1999

3. Time of Death

6:10 AM

4a. Facility Name (If not institution, give street and number)

Wilson Health Care Center

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

577-09-3478

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Aug. 7, 1907

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

201 Russell Avenue

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

William Burrows Hudson

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Johnstone

19a. Informant's Name/Relationship (Type, Print)

Richard H. Mayfield/Attorney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4910 Massachusetts Ave., N.W., Wasington, DC 20016

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parklawn Memorial Park

Date

5/18/99

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr., Gaithersburg, MD. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cerebral Vascular Accident

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 week

b. Atrial Fibrillation

Due to (or as a consequence of):

years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

041794

29d. Date signed (Month, Day, Year)

May 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Priscilla Callahan-Lyon, MD

911 Russell Ave Gaithersburg, MD 20879

State
Registrar

31. Date filed (Month, Day, Year)

MAY 18 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17534

| | | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARION FRANCIS SHERILL | | | | | | 2. Date of Death
Month MAY Day 19 Year 1999 | | 3. Time of Death
01:40 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Holy Cross Hospital | | | | | | 4b. City, Town, or Location of Death
Silver Spring | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
428-34-8441 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
87 Yrs. | | 8. Date of Birth (Month, Day, Year)
JAN 16 1912 | | 9. Birthplace (State or Foreign Country)
Mississippi | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
10216 Tenbrook Drive | | | | 10f. Zip Code
20901 | | 10g. Citizen of What Country?
USA | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Registered Nurse | | | 16b. Kind of Business/Industry
Health Care | | | |
| 17. Father's Name (First, Middle, Last)
Charles Cargill | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Marion Bledsoe | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Deborah Jean Sherrill (daughter) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10216 Tenbrook Drive Silver Spring, Maryland 20901 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Roseland Park | | 20c. Location - City or Town, State
5/25/99 Hattiesburg, Mississippi | | | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 20901 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Urosepsis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
stroke
Due to (or as a consequence of):

Approximate Interval Between Onset and Death
3 days | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
stroke | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | | | 29c. License number
D37891 | | 29d. Date signed (Month, Day, Year)
MAY 20, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
A RAJIVANSHI MD 121 Congressional Ln # 409 Rockville MD 20852 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 21 1999 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-17535

Physician
/Medical
ExaminerFuneral
Director

| | | | | | |
|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)
Tangerine Sokol | | 2. Date of Death
Month Day Year
May 18, 1999 | | 3. Time of Death
12:15 AM | |
| 4a. Facility Name (If not institution, give street and number)
Manor Care-Potomac | | | 4b. City, Town, or Location of Death
Potomac | | 4c. County of Death
Montgomery |
| 5. Social Security Number
557-62-1420 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
53 Yrs. | 8. Date of Birth (Month, Day, Year)
June 16, 1945 | 9. Birthplace (State or Foreign Country)
Washington, DC | |
| Usual Residence of Decedent | | | | | |
| 10a. State
Maryland | 10b. County
Montgomery | 10c. City, Town or Location
Rockville | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number
609 Douglas Avenue | | 10f. Zip Code
20850 | | 10g. Citizen of What Country?
United States | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
American Indian/White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
4 | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Minister | | 16b. Kind of Business/Industry
Religion | | | |
| 17. Father's Name (First, Middle, Last)
Thomas Lewis | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ozella Stephenson | | |
| 19a. Informant's Name/Relationship (Type, Print) (daughter)
Rachel Ozella Charity Unsire | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
609 Douglas Avenue, Rockville, Maryland 20850 | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory | | 20c. Location - City or Town, State
5-19-99 Beltsville, Maryland | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Rapp Funeral Services, P.A.
933 Gist Avenue, Silver Spring, Maryland 20910 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Breast Cancer
Due to (or as a consequence of):
b. Pulmonary Emboli
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d. _____ | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and Title of Certifier
 | | 29c. License number
D 35792 | | 29d. Date signed (Month, Day, Year)
May 18, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Swaroop G. Rao, M. D., 50 West Edmondston Drive, #504, Rockville, MD 20852 | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 20 1999 | | 32. Registrar's Signature
 | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|--|---|---|--------------------------------|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ADELLE A. STATEN | | | | 2. Date of Death
Month Day Year
May 19 1999 | | 3. Time of Death
3:55 A.M. | |
| | 4a. Facility Name (If not Institution, give street and number)
MANOR CARE HEALTH SERVICE | | | | 4b. City, Town, or Location of Death
CHEVY CHASE | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
231 14 3308 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
89 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Nov. 15, 1909 | 9. Birthplace (State or Foreign Country)
Tunis, N.C. |
| | Usual Residence of Decedent | | | | 10c. City, Town or Location
Washington, D.C. | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. State | | 10b. County | | 10f. Zip Code
20012 | | 10g. Citizen of What Country?
United States | |
| | 10e. Street and Number
700 Fern Pl., N.W. | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Home | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 17. Father's Name (First, Middle, Last)
Gurney C. Anderson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Carrie Beverly | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Florence S. Boone (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
700 Fern Pl., N.W., Washington, D.C. 20012 | | | |
| Physician
/Medical
Examiner | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Calvary Cemetery | | Date
5/20/99 | | 20c. Location - City or Town, State
Norfolk, Virginia | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
McGuire Funeral Service Inc.
7400 Georgia Ave., N.W., Washington, D.C. 20012 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. ASPIRATION PNEUMONIA
Due to (or as a consequence of):
b. DYSPHAGIA
Due to (or as a consequence of):
c. LATE EFFECTS OF CEREBRAL VASCULAR ACCIDENTS
Due to (or as a consequence of):
d.
Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death
1-2 months |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
GASTROSTOMTUBI, HYPERTENSION, DECUBITUS ULCER | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| | 29b. Signature and title of certifier
 | | | | 29c. License number
D35579 | | 29d. Date signed (Month, Day, Year)
May 19, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Susan Jaffe Miller, M.D., 6844 Tulip Hill Terrace, Bethesda, Maryland 20816 | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
MAY 21 1999 | | | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17537

| | | | | | | | | |
|---|--|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Regina Sutton | | | | 2. Date of Death
Month May Day 17 , Year 1999 | | 3. Time of Death
7:15P. | |
| | 4a. Facility Name (If not institution, give street and number)
Mariner Health Care of Greater Laurel | | | | 4b. City, Town, or Location of Death
Laurel | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
578-48-4348 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
62 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 18, 1936 | |
| | 9. Birthplace (State or Foreign Country)
Washington, D.C. | | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Laurel | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
14200 Laurel Park Drive | | 10f. Zip Code
20707 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
own home | | | |
| | 17. Father's Name (First, Middle, Last)
Eugene Linkous | | 18. Mother's Name (First, Middle, Maiden Surname)
Myrtle Hanks | | 19a. Informant's Name/Relationship (Type, Print)
Blaine W. Sutton (son) | | | |
| To Be Completed by Physician/Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10513 Pilla-Terra Ct. Laurel, Maryland 20723 | | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Old Savannah Cemetery May 20, 1999 Sylva, North Carolina | | 20c. Location - City or Town, State | |
| | 21. Signature of Funeral Service Licensee
Donald V. Borgwardt | | 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 20705 | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Biliary Cirrhosis of liver | | | | | | Approximate Interval Between Onset and Death
5 years | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23c. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | 29b. Signature and title of certifier
M.S. | |
| | 29c. License number
24721 | | 29d. Date signed (Month, Day, Year)
May 18, 1999 | | | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Syed A. Sadiq, M.D. 14333 Laurel Bowie Rd., #208 Laurel, Maryland 20708 | | | | | | 31. Date filed (Month, Day, Year)
MAY 19 1999 | |
| | 32. Registrar's Signature
B. Sparks | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-17538

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William E. Sanders

2. Date of Death

Month Day Year
May 14, 1999

3. Time of Death

11:15 AM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

243-42-4166

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 23, 1931

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

261 Congressional Lane, #502

10f. Zip Code

20852

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No 1953-
If Yes, Give Year or Dates: 195813. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Public Information Specialist of Health

16b. Kind of Business/Industry

National Institutes

17. Father's Name (First, Middle, Last)

James M. Sanders

18. Mother's Name (First, Middle, Maiden Surname)

Raymond Broadwell

19a. Informant's Name/Relationship (Type, Print)

Charlotte T. Sanders (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as 10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Crematory

Date

5-15-99

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Green H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P. A.
933 Gist Avenue, Silver Spring, MD 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Multiple organ system Failure
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

1 week

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Sepsis
Due to (or as a consequence of):

8 days

c. Pneumonia and Bacteremia
Due to (or as a consequence of):

8 days

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure

DIC

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Joseph Fontana, MD

29c. License number

50718

29d. Date signed (Month, Day, Year)

5-14-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH FONTANA, MD 8600 Old Georgetown RD, BETHESDA, MD 20814

State
Registrar

31. Date filed (Month, Day, Year)

MAY 17 1999

32. Registrar's Signature

Benita B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17539

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **ORA LEE STERLING** 2. Date of Death Month **May** Day **10** Year **1999** 3. Time of Death **2:35 P.M.**

Funeral
Director

4a. Facility Name (If not institution, give street and number) **McCready Memorial Hospital** 4b. City, Town, or Location of Death **Crisfield** 4c. County of Death **Somerset**

5. Social Security Number **217-14-8496** 6. Sex ☒ M ☐ F 7. Age (In yrs. last birthday) **76** Yrs. 8. Date of Birth (Month, Day, Year) **February 21, 1923** 9. Birthplace (State or Foreign Country) **Maryland**

Usual Residence of Decedent

10a. State **Maryland** 10b. County **Somerset** 10c. City, Town or Location **Crisfield** 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number **10 Wynfall Avenue** 10f. Zip Code **21817** 10g. Citizen of What Country? **U.S.A.**

11. Marital Status ☐ Never Married ☐ Married ☐ Widowed ☒ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: **W. W. II** 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **Grade 7** College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Heavy Equipment Operator** 16b. Kind of Business/Industry **Construction**

17. Father's Name (First, Middle, Last) **Bennett T. Sterling** 18. Mother's Name (First, Middle, Maiden Surname) **Mabel E. Landon**

19a. Informant's Name/Relationship (Type, Print) **Shirley Jones (Sister)** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **4586 Charlie Swift Rd. - Crisfield, MD 21817**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **American Legion Cemetery** Date **5/13/99** 20c. Location - City or Town, State **Crisfield, MD**

21. Signature of Funeral Service Licensee **Robert H. Bradshaw, Jr.** 22. Name and Address of Facility **Bradshaw & Sons Funeral Home** **306 W. Main St. - Crisfield, MD 21817**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) **a. CONGESTIVE HEART FAILURE** YEARS **b. A S C V D** YEARS **c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last** Due to (or as a consequence of): **d.**

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☒ Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier **[Signature]** 29c. License number **D 51086** 29d. Date signed (Month, Day, Year) **May 12, 1999**

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) **Eshwar Kanchana, M.D. - 320 W. Main St. - Crisfield, MD 21817**

State
Registrar

31. Date filed (Month, Day, Year) **MAY 14 1999** 32. Registrar's Signature **[Signature]**

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

JERMAINE L. SISCO
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17540

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
DirectorPhysician
/Medical
Examiner

| | | | | |
|--|--|---|-------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)
JERMAINE LAMONT SISCO | | 2. Date of Death
Month MAY Day 16 Year 1999 | | 3. Time of Death
0602 |
| 4a. Facility Name (If not institution, give street and number)
PENINSULA REGIONAL HOSPITAL | | 4b. City, Town, or Location of Death
SALISBURY | | 4c. County of Death
WICOMICO |
| 5. Social Security Number
220-74-4908 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
27 Yrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country)
MD. |
| Usual Residence of Decedent | | | | |
| 10a. State
MD. | 10b. County
TALBOT | 10c. City, Town or Location
TRAPPE | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number
3876 HARRISON CIRCLE | | 10f. Zip Code
21673 | | 10g. Citizen of What Country?
U.S.A. |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MACHINE OPERATOR | | 16b. Kind of Business/Industry
STAR DEMOCRAT | | |
| 17. Father's Name (First, Middle, Last)
ABE SISCO JR. | | 18. Mother's Name (First, Middle, Maiden Surname)
JOAANE WILSON | | |
| 19a. Informant's Name/Relationship (Type, Print)
JOANNE SISCO/ MOTHER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. BOX 14 RIDGLEY, MD. 21660 | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHAPEL CEMETERY | | 20c. Location - City or Town, State
5/22/99 EASTON, MD |
| 21. Signature of Funeral Service Licensee
Eric L. Dashiell | | 22. Name and Address of Facility
DASHIELL FUNERAL SERVICES
319 E. DOVER ST. EASTON, MD. 21601 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Multiple injuries
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
5-16-99 | | 28b. Time of Injury
0410 M |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
Automobile accident | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Street | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Easton-Trappe Road Wicomico County, Maryland | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| 29b. Signature and title of certifier
Allysh A. Macky, MD | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
MAY 17, 1999 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201 | | | | |
| 31. Date filed (Month, Day, Year)
MAY 20 1999 | | 32. Registrar's Signature
B. Sparks | | |

U S YAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17541

| | | | | | | | | |
|---|--|---|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
NINA MAE STALLINGS | | | | 2. Date of Death
Month Day Year
MAY 8 1999 | | 3. Time of Death
7:45 PM | |
| | 4a. Facility Name (If not institution, give street and number)
106 MAPLE AVENUE | | | | 4b. City, Town, or Location of Death
PRESTON | | 4c. County of Death
CAROLINE | |
| Funeral
Director | 5. Social Security Number
406-36-0740 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
78 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
APR. 4, 1921 | |
| | 9. Birthplace (State or Foreign Country)
KENTUCKY | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | | |
| | 10a. State
MD | | 10b. County
CAROLINE | | 10c. City, Town or Location
PRESTON | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 10e. Street and Number
106 MAPLE AVENUE | | | 10f. Zip Code
21655 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
8 | | College (1-4 or 5+)
-0- | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
OWN HOME | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
FRANK T. BRUNER | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MELISSA A. CRAFT | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
JERRY D. STALLINGS/ SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. BOX 487, PRESTON, MD 21655 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MARYLAND VETERAN CEMETERY | | Data
5-13-99 | | 20c. Location - City or Town, State
HURLOCK, MD | |
| | 21. Signature of Funeral Service Licensee
Joseph M. Ostrowski; | | | | 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, P.A.
200 S. HARRISON ST., EASTON, MD 21601 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. Diabetes mellitus
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dementia Hypertension | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
David G. Oliver MD | | 29c. License number
D39749 | | 29d. Date signed (Month, Day, Year)
5/10/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David G. Oliver MD 503 Dutchmans Lane Easton MD 21601 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 10 1999 | | 32. Registrar's Signature
B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17542

| | | | | | | | | | | | |
|--|--|---|--|--|--|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Richard Patrick TIMMINS | | | | 2. Date of Death
Month Day Year
May 13, 1999 | | | | 3. Time of Death
0715 | | |
| | 4a. Facility Name (If not institution, give street and number)
Washington County Hospital | | | | 4b. City, Town, or Location of Death
Hagerstown | | | | 4c. County of Death
Washington | | |
| Funeral
Director | 5. Social Security Number
188-03-5564 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
85 | | 8. Date of Birth (Month, Day, Year)
Dec. 4, 1913 | | 9. Birthplace (State or Foreign Country)
Pennsylvania | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Washington | | 10c. City, Town or Location
Hagerstown | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
10842 Oak Valley Drive | | | | 10f. Zip Code
21740 | | | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
carpenter | | | | 16b. Kind of Business/Industry
construction | | | |
| 17. Father's Name (First, Middle, Last)
Arthur Joseph Timmins | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Caroline Rhuland | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Theresa V. Timmins - wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10842 Oak Valley Dr., Hagerstown, Md. 21740 | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenlawn Mem. Park | | Date
5/15/99 | | 20c. Location - City or Town, State
Williamsport, Maryland | | | | | |
| 21. Signature of Funeral Service Licensee
Fried L. Westel | | | | 22. Name and Address of Facility
MINNICH FUNERAL HOME
415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death)
a. Acute Pulmonary Embolus
Due to (or as a consequence of): | | | | | | | | | | 30 min | |
| Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Acute Thrombophlebitis
Due to (or as a consequence of): | | | | | | | | | | 2 day | |
| c. Acute Left ankle Fracture
Due to (or as a consequence of): | | | | | | | | | | 1 wk | |
| d. | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Severe Atherosclerotic Vascular Disease with occlusive carotid artery disease, organic heart disease, COPD | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
Mary E. Money MD | | | | 29c. License number
D23815 | | | | 29d. Date signed (Month, Day, Year)
5/13/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mary E. Money, M. D., 354 Mill Street, Hagerstown, Md. 21740 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1999 | | | | 32. Registrar's Signature
Barbara B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17543

| | | | | | | | | |
|---|--|---|--|--|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Louis Anthony Tito, Sr. | | | | 2. Date of Death
Month May Day 12 Year 1999 | | 3. Time of Death
8:00 pm | |
| | 4a. Facility Name (If not institution, give street and number)
Williamsport Nursing Home | | | | 4b. City, Town, or Location of Death
Williamsport | | 4c. County of Death
Washington | |
| Funeral
Director | 5. Social Security Number
057-10-6332 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
91 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
Nov. 11, 1907 | 9. Birthplace (State or Foreign Country)
New York |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
West Virginia | | 10b. County
Berkeley | | 10c. City, Town or Location
Martinsburg | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
Rt. 6 Box 87 | | | | 10f. Zip Code
25401 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Bookkeeper | | 16b. Kind of Business/Industry
Electric Company | | |
| 17. Father's Name (First, Middle, Last)
Antonio Tito | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Maria Rago | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Dr. Eleanore M. Hill/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 6 Box 87 Martinsburg, West Virginia 25401 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenlawn Memorial Park | | Date
5-14-99 | | 20c. Location - City or Town, State
Williamsport, Maryland | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Osborne Funeral Home
425 S. Conococheague St. Williamsport, MD 21795 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
PNEUMONIA
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
EMPHYSEMA
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death
10 DAYS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
EMPHYSEMA | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D33700 | | 29d. Date signed (Month, Day, Year)
MAY 13, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
TED E. HOWE 7542 OVERLOOK DR. BOWENBORO MD 21713 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 14 1999 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17564

| | | | | | | | | | | | | | | | | | | | | | |
|---|--|--------------------------------|---|---|--|--------------------------|---|--|--|---|----|--------------------|----------------------------------|--|--|----|--------|----|----------------------|----|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ruth T. Taylor | | | | 2. Date of Death
Month Day Year
May 16, 1999 | | | | 3. Time of Death
3:20 AM | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Prince Georges Hospital Center | | | | 4b. City, Town, or Location of Death
Cheverly, MD | | | | 4c. County of Death
Prince George's | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
281-12-6116 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (in yrs. last birthday)
83 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 2, 1915 | | 9. Birthplace (State or Foreign Country)
Ohio | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Mitchellville | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | |
| 10e. Street and Number
12004 Shadystone Terrace | | | | 10f. Zip Code
20721 | | | | 10g. Citizen of What Country?
United States | | | | | | | | | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretary | | | | 16b. Kind of Business/Industry
U.S. Government | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
Julius Ceasar Turner | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lula Belle Mitchell | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Sandra Williams Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12004 Shadystone Terrace, Mitchellville, MD 20721 | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln Memorial | | Date
5/20/99 | | 20c. Location - City or Town, State
Suitland, Maryland | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
<i>Thomas B. Clyburn</i> | | | | 22. Name and Address of Facility
McGuire Funeral Service, Inc.
7400 Georgia Avenue, N.W., Washington, D.C. | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Hemorrhagic Stroke</td> <td rowspan="4"> Due to (or as a consequence of): </td> <td rowspan="4"></td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>Sepsis</td> </tr> <tr> <td>c.</td> <td>Aspiration Pneumonia</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Hemorrhagic Stroke | Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | b. | Sepsis | c. | Aspiration Pneumonia | d. | |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Hemorrhagic Stroke | Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | | | | | | | | | | | | | | | | |
| | b. | Sepsis | | | | | | | | | | | | | | | | | | | |
| | c. | Aspiration Pneumonia | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | |
| Urinary Tract Infection | | | | | | | | | | | | | | | | | | | | | |
| Gastritis, Hypertension | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | |
| Parkinsons Disease | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | |
| | | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
<i>Yisa O. Yussuf</i> | | | | 29c. License number
D51083 | | | | | | | | | | | | | |
| | | | | 29d. Date signed (Month, Day, Year)
May 17, 1999 | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Yisa O. Yussuf, M.D. 6712 Village Park Drive Greenbelt, MD 20770 | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 19 1999 | | | | 32. Registrar's Signature
<i>James B. Sparks</i> | | | | | | | | | | | | | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17545

| | | | | | | | | | | | | | | | | | | | |
|--|---|--|---|---|--|---|--|--|---|---|----|--|--|----|----------------------------------|----|----------------------------------|----|----------------------------------|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Timothy J. Tehan | | | | | | 2. Date of Death
Month Day Year
May 17, 1999 | | 3. Time of Death
6:00 P.M. | | | | | | | | | | |
| | 4a. Facility Name (If not Institution, give street and number)
8101 Connecticut Ave. #N-610 | | | | | | 4b. City, Town, or Location of Death
Chevy Chase | | 4c. County of Death
Montgomery | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
106-24-7980 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
71 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 11, 1927 | | 9. Birthplace (State or Foreign Country)
New York | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | |
| 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Chevy Chase | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| 10e. Street and Number
8101 Connecticut Avenue N-610 | | | | 10f. Zip Code
20815 | | 10g. Citizen of What Country?
U. S. A. | | | | | | | | | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: Korea | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
5 + | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Physician | | | 16b. Kind of Business/Industry
Medicine | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
Timothy Tehan | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Wayrick | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Timothy R. Tehan - Son | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10407 Snow Point Drive Bethesda, MD 20814 | | | | | | | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery | | Date
5/21/99 | | 20c. Location - City or Town, State
Silver Spring, MD | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
Joseph Gawler's Sons INC, 5130 Wisconsin Ave. NW, Washington, DC 20016 | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Arteriosclerotic Cardiovascular Disease</td> <td rowspan="4"> Approximate Interval Between Onset and Death

 Immediate </td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Arteriosclerotic Cardiovascular Disease | Approximate Interval Between Onset and Death

Immediate | b. | Due to (or as a consequence of): | c. | Due to (or as a consequence of): | d. | Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Arteriosclerotic Cardiovascular Disease | Approximate Interval Between Onset and Death

Immediate | | | | | | | | | | | | | | | | |
| | b. | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | |
| | c. | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | |
| | d. | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | |
| | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and Title of Certifier
 | | | | | | 29c. License number
DO-1948 | | 29d. Date signed (Month, Day, Year)
May 18, 1999 | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Blaine Fitzgerald, M. D. 8218 Wisconsin Ave. Bethesda, MD 20814-3107 | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 20 1999 | | | 32. Registrar's Signature
 | | | | | | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

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10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17546

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)
Aida Margarita Terradas | | | | | | 2. Date of Death
Month May Day 14 Year 1999 | | 3. Time of Death
2:30 P.M. | |
| 4a. Facility Name (If not institution, give street and number)
Mariner Health of Bethesda | | | | | | 4b. City, Town, or Location of Death
Bethesda | | 4c. County of Death
Montgomery | |
| 5. Social Security Number
245-90-3234 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
86 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 25, 1912 | | 9. Birthplace (State or Foreign Country)
Cuba | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
4002 Rickover Road | | | | 10f. Zip Code
20902 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: Cuban | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Own Home | | |
| 17. Father's Name (First, Middle, Last)
Juan Vega | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Estelvina Martinez | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Marta M. Sanchez (daughter) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4002 Rickover Road Silver Spring, Maryland 20902 | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | Date
5/17/99 | | 20c. Location - City or Town, State
Alexandria, Virginia | |
| 21. Signature of Funeral Service Licensee
<i>Andrew J. Cole</i> | | | | 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 20901 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Renovatio
Hypertension | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>Dr. Schuman MD</i> | | 29c. License number
DL0516 | | 29d. Date signed (Month, Day, Year)
May 17, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Schuman MD 9400 Old Georgetown Rd Bethesda, MD 20814 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 18 1999 | | 32. Registrar's Signature
<i>Geneva B. Sparks</i> | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17547

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CATHERINE B. TRIMBLE

2. Date of Death

Month Day Year
MAY 19 1999

3. Time of Death

10:45 AM

4a. Facility Name (If not institution, give street and number)

HEARTLAND NURSING HOME

4b. City, Town, or Location of Death

ADELPHI

4c. County of Death

PRINCE GEORGE'S

Funeral
Director

5. Social Security Number

445-10-7043

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct. 26, 1915

9. Birthplace (State or Foreign Country)

Oklahoma

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

College Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9314 Cherry Hill Road Apt. 207

10f. Zip Code

20740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Furniture

17. Father's Name (First, Middle, Last)

Michael Bartlett

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Stadden

19a. Informant's Name/Relationship (Type, Print)

Patricia A. Abrams (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9314 Cherry Hill Road #207 College Park, Maryland 20740

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

5/20/99

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

William L. Byrd

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE LUNG DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

ATKINSON
PHYSICIAN

29c. License number

DA2749

29d. Date signed (Month, Day, Year)

5/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9831 GREENBELT ROAD STE 101 LANHAM MD 20706

State
Registrar

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17518

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edgar William Tullar, Sr.

2. Date of Death

May 14, 1999

3. Time of Death

4:15 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

579-07-5683

6. Sex

15 M 2 F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 16, 1920

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

1220 East West Highway #1424

10f. Zip Code

20910

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give

Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Director of Management Operations

16b. Kind of Business/Industry

Tower Construction

17. Father's Name (First, Middle, Last)

Irving Meridith Tullar

18. Mother's Name (First, Middle, Maiden Surname)

Grace Leighila Corey

19a. Informant's Name/Relationship (Type, Print)

Hazel B. Tullar (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1220 East West Highway #1424 Silver Spring, Maryland 20910

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Mount Comfort Cemetery

Date

5/19/99 Alexandria, Virginia

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

J. Ken Skels

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPTIC SHOCK

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. STAPH AUREUS BACTEREMIA

Due to (or as a consequence of):

10 DAYS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

RESPIRATORY FAILURE

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

D35941

29d. Date signed (Month, Day, Year)

MAY 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PURAN P. MATHUR, M.D.

#401 50 W. EDMONSTON DR. ROCKVILLE, MD 20852

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

G. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Virginia
me, Inc.
Liver Spring, MD 209

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17550

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)
CHARLES ARCHIE TURNER | | | | 2. Date of Death
Month Day Year
MAY 17, 1999 | | 3. Time of Death
12:01 am | |
| 4a. Facility Name (If not institution, give street and number)
TALBOT HOSPICE FOUNDATION | | | | 4b. City, Town, or Location of Death
EASTON | | 4c. County of Death
TALBOT | |
| 5. Social Security Number
217-01-8089 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
85 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
AUG. 23, 1913 | |
| 9. Birthplace (State or Foreign Country)
MD. | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
TALBOT | | 10c. City, Town or Location
EASTON | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
119 S. LOCUST ST. | | | | 10f. Zip Code
21601 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 06 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
LABORER | | 16b. Kind of Business/Industry
ENVIRONMENTAL | |
| 17. Father's Name (First, Middle, Last)
SAMUEL HARRIS | | | | 18. Mother's Name (First, Middle, Maiden Surname)
NANNY PRITCHETT | | | |
| 19a. Informant's Name/Relationship (Type, Print)
ALBERT HARRIS/ BROTHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
25813 SKIPTON CORDOVA RD. CORDOVA, MD. 21625 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHAPEL CEMETERY | | 20c. Location - City or Town, State
EASTON, MD. | | Approximate Interval Between Onset and Death | |
| 21. Signature of Funeral Service Licensee
Eric L. Dashiell | | | | 22. Name and Address of Facility
DASHIELL FUNERAL SERVICES
319 E. DOVER ST. EASTON, MD. 21601 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

e. Lung cancer
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of): | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospitel: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier
[Signature] MD | | | | 29c. License number
D25450 | | 29d. Date signed (Month, Day, Year)
5/19/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ROBERT B. SANCHEZ MD 508 IDLEWILD AVE. EASTON, MD. 21601 | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 20 1999 | | | | 32. Registrar's Signature
[Signature] | | | |

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17551

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Leon Charles Vaughn III

2. Date of Death
Month Day Year
May 16 1999

3. Time of Death

9:54 P.M.

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

220-52-1290

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

50

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Sept. 12, 1948

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

20025 Leitersburg Pike

10f. Zip Code

21742

10g. Citizen of What Country?

U.S.A

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates: 64-67

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Welder

16b. Kind of Business/Industry

Metal Products

17. Father's Name (First, Middle, Last)

Leon Charles Vaughn Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Kathleen Martin

19a. Informant's Name/Relationship (Type, Print)

Linda K. Vaughn (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20025 Leitersburg Pike Hagerstown, Md. 21742

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ringgold Cemetery

Date

May 20, 1999 Ringgold, Md.

20c. Location - City or Town, State

21. Signature of Funeral Service Licenses

Pennis L. Davis

22. Name and Address of Facility

12525 Bradbury Ave.
Davis Funeral Home Smithsburg, Md. 21783

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPTIC SHOCK

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1-2 hrs

b. PNEUMONIA

Due to (or as a consequence of):

24 hrs

Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NICOTINE ADDICTION

DIABETES MELLITUS, MODM

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital: ☐ Inpatient ☒ ER/Outpatient ☐ DCA

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Accident ☐ Suicide ☐ Homicide
☐ Pending investigation ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? ☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dan H. McDougal

29c. License number

D21470

29d. Date signed (Month, Day, Year)

5/17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAN MCDUGAL, M.D. 1110 MED. CAMPUS DR HAGERSTOWN 21742

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17552

| | | | | | | | | |
|---|---|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Edith Kondell Vogel | | | | 2. Date of Death
Month May Day 17 Year 1999 | | 3. Time of Death
6:30 AM | |
| | 4a. Facility Name (If not institution, give street and number)
5616 Wilson Lane | | | | 4b. City, Town, or Location of Death
Bethesda | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
060 07 9332 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (in yrs. last birthday)
91 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 24 1907 | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country)
New Jersey | | 10. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Bethesda | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
5616 Wilson Lane | | | | 10f. Zip Code
20814 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretary | | 16b. Kind of Business/Industry
Clerical | | |
| 17. Father's Name (First, Middle, Last)
Harry Kondell | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Eva Lewis | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Lynn Vogel Wilson/ Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5616 Wilson La. Bethesda Md. 20814 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
George Washington Univ. Med. Ctr. | | 20c. Location - City or Town, State
Washington DC | | 20d. Date
5/17/99 | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Columbia Mortuary Services
PO Box 58007 Washington DC 20037 | | | | |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Congestive heart failure
Due to (or as a consequence of):

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____ | | | | | | | | |
| 23b. Approximate Interval Between Onset and Death
2 years | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D21611 | | 29d. Date signed (Month, Day, Year)
5/18/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John L. Barr, M.D.
10810 Connecticut Ave, Kensington, Md 20895 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 19 1999 | | | | 32. Registrar's Signature
 | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

ADH
WILLIAM C VETTER
992974-025

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, 27, 28A-F PER MEO G772 6-2-99 WR.

Certificate of Death

Reg. No.

99 17553

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Christopher Vetter

2. Date of Death

Month Day Year
MAY 22, 1999

3. Time of Death

1358 PM

4a. Facility Name (If not institution, give street and number)

3820 WASHINGTON AVENUE

4b. City, Town, or Location of Death

ABINGDON

4c. County of Death

HARFORD

Funeral
Director

5. Social Security Number

218-60-4674

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

45

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 25, 1953

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Abingdon

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3820 Washington Ave.

10f. Zip Code

21009

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Road Construction

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

William Melvin Vetter III

18. Mother's Name (First, Middle, Maiden Summa)

Anna Mae Eiler

19a. Informant's Name/Relationship (Type, Print)

Anna M. Vetter / Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3820 Washington Ave., Abingdon, MD 21009

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery

Date

5-27-99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Charles A. Emery

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

COMBINED DRUG INTOXICATION

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of causa of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending Investigation
☐ Accident ☒ Suicide
☐ Homicide ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)
Found:
5-22-99

28b. Time of Injury

UNKNOWN M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State) 3820 WASHINGTON, ABINGDON, MD.

29a. Certifier (Check one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John Locke MD

29c. License number

OCME

29d. Date signed (Month, Day, Year)

MAY 23, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Locke MD

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

MAY 23 1999

32. Registrar's Signature

Beverly B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

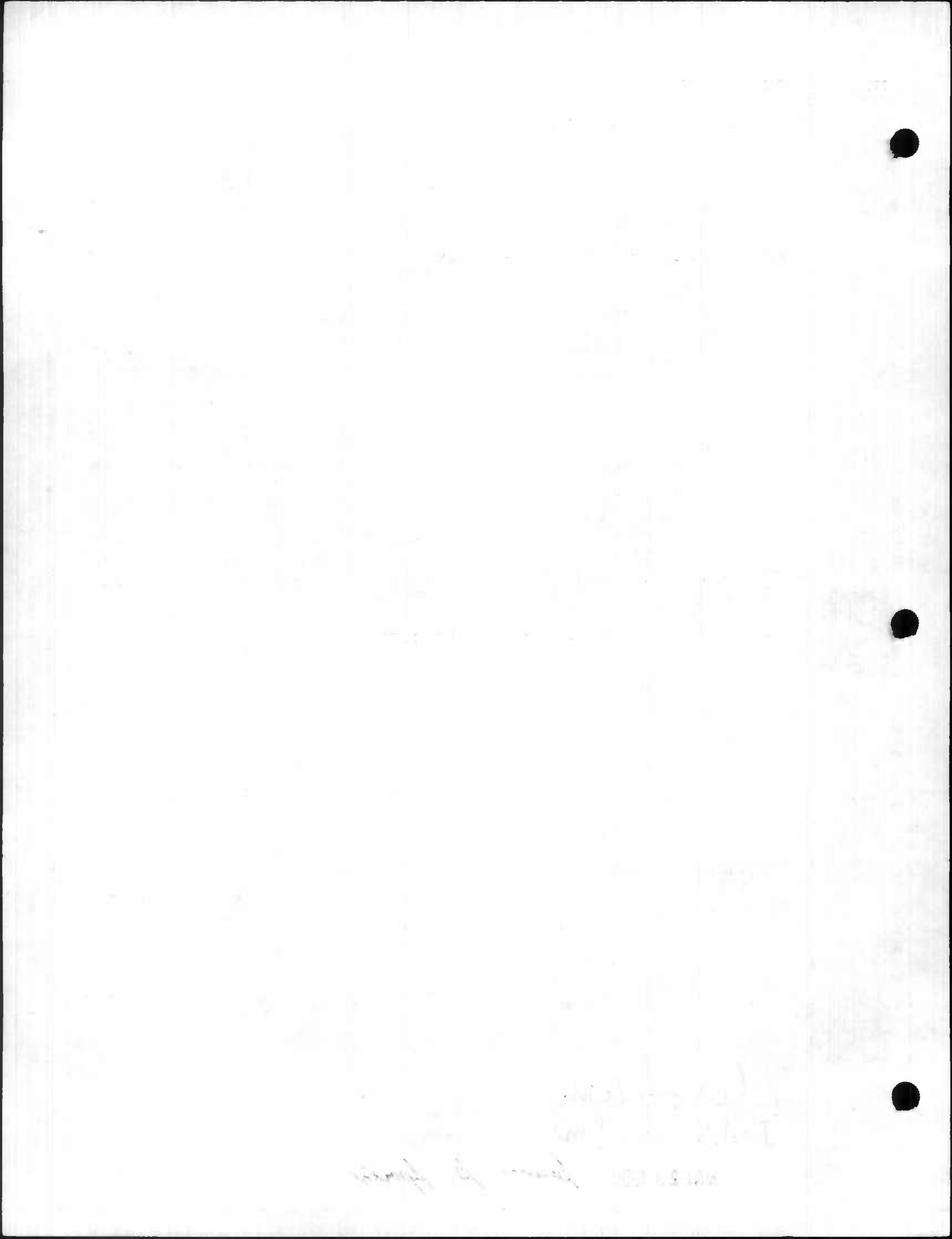
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17551

| | | | | | | | | |
|---|---|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EDWARD JOSEPH WEAVER, SR. | | | | 2. Date of Death
Month Day Year
MAY 17, 1999 | | 3. Time of Death
3:30PM | |
| | 4a. Facility Name (If not institution, give street and number)
ST. MARY'S HOSPITAL | | | | 4b. City, Town, or Location of Death
LEONARDTOWN | | 4c. County of Death
ST. MARY'S | |
| Funeral
Director | 5. Social Security Number
716-16-0066 | | 6. Sex
XX M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
80 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 27, 1918 | |
| | 9. Birthplace (State or Foreign Country)
Pennsylvania | | 10a. State
Maryland | | 10b. County
St. Mary's | | 10c. City, Town or Location
Mechanicsville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
27347 Tin Top School Road | | 10f. Zip Code
20659 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 3 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Statistician | | 16b. Kind of Business/Industry
U.S. Federal Government | | | |
| | 17. Father's Name (First, Middle, Last)
HARRY REED WEAVER | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ROSE ELIZABETH SHARP | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Mary Ellen Marlow/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
27347 Tin Top School Road, Mechanicsville, Md 20659 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans' Cem. 05-24-1999 Cheltenham, Maryland | | 20c. Location - City or Town, State | | 20d. Date | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
JOHN P. KNISLEY MO1164 | | | | 22. Name and Address of Facility
The Hunt Funeral Home, Inc.
P.O. Box 156, Waldorf, Maryland 20604 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Probable Myocardial Infarction
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Renal Failure | | | | 23c. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
Dr. William D. Boyd II | | 29c. License number
014285 | |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)
5-18-99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. WILLIAM D. BOYD II LEONARDTOWN, MD. 20650 | | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 21 1999 | | 32. Registrar's Signature
James B. Sparks | | | | | |

DAVID LUTHER WINTERS

ITEMS: #23 PART 1, 27, 28A-F PER MEQ G772 6-28-99 WR.

Certificate of Death

Reg. No.

99 17555

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

David Luther WINTERS, Sr.

2. Date of Death

MAY 17, 1999

3. Time of Death

23:22 PM

4a. Facility Name (If not institution, give street and number)

SACRED HEART HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral
Director

5. Social Security Number

220-42-6013

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 14, 1946

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1041 H Noland Drive

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

janitorial

16b. Kind of Business/Industry

assorted businesses

17. Father's Name (First, Middle, Last)

Jack Winters

18. Mother's Name (First, Middle, Maiden Summa)

Catherine Dunn

19a. Informant's Name/Relationship (Type, Print)

Ronda L. Gipe - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

104 S. Conococheague St., Williamsport, Md. 21795

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Rest Haven Cemetery

Date

5-21-99

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Scott M. Munnich

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

MULTIPLE INJURIES

a. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☒ Could not be determined

28a. Date of Injury

(Month, Day, Year)

MAY 17, 1999

28b. Time of Injury

11:01

A

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

ROADWAY

28d. Describe how injury occurred

DRIVER IN MOTOR VEHICLE ACCIDENT

28f. Location (Street and Number or Rural Route Number,

City or Town, State) 68 EAST AT 220,

CUMBERLAND, MD,

29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Theodore H. King

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

MAY 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODORE H. KING

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

Geneva B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-17556

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|--|--|---|--|--|--------------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last)
Mildred Ruth Weller | | | | 2. Date of Death
Month May Day 13 Year 1999 | | 3. Time of Death
0540 | |
| 4a. Facility Name (If not institution, give street and number)
Washington County Hospital | | | | 4b. City, Town, or Location of Death
Hagerstown | | 4c. County of Death
Washington | |
| 5. Social Security Number
219-20-0363 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
74 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
March 25, 1925 | 9. Birthplace (State or Foreign Country)
Maryland |
| Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Washington | | 10c. City, Town or Location
Funkstown | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
109 N. High Street | | | | 10f. Zip Code
21734 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Blocker | | 16b. Kind of Business/Industry
Ribbon Manufacturer | |
| 17. Father's Name (First, Middle, Last)
Charles Edward Brandt | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Gladys Bolitho | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Vicki Eccard/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1320 Knighton Lane Falling Waters, WV 25419 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenlawn Memorial Park | | Date
5-18-99 | | 20c. Location - City or Town, State
Williamsport, Maryland | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Osborne Funeral Home
425 S. Conococheague St. Williamsport, MD 21795 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Euphysema
Due to (or as a consequence of):
Chyloperfusion

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Coronary artery disease
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death
> 10 years
1 week | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Coronary artery disease | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Samuel Chan | | 29c. License number
D36655 | | 29d. Date signed (Month, Day, Year)
May 13, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
1185 Mt. Aetna Rd. Hagerstown MD 21740 | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1999 | | 32. Registrar's Signature
G. Sparks | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

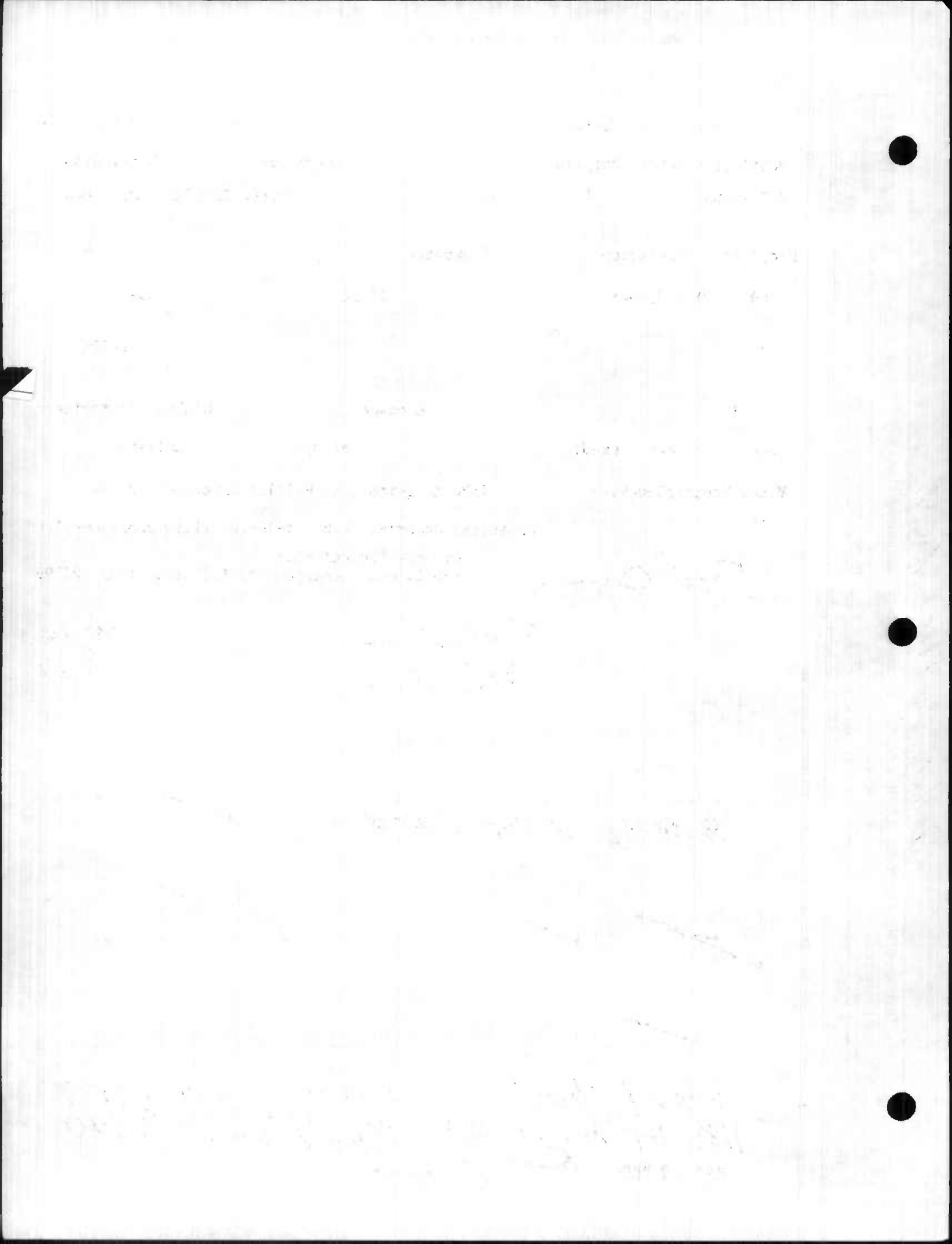
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17557

| | | | | | | | | | | |
|--|---|--|---|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
William Ernest Whaley | | | | | 2. Date of Death
Month Day Year
May 13, 1999 | | | 3. Time of Death
8:12 am | |
| | 4a. Facility Name (If not institution, give street and number)
Kent & Queen Anne's Hospital | | | | | 4b. City, Town, or Location of Death
Chestertown | | | 4c. County of Death
Kent | |
| Funeral
Director | 5. Social Security Number
218-34-3374 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
62 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 6, 1936 | | 9. Birthplace (State or Foreign Country)
Pennsylvania | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Kent | | 10c. City, Town or Location
Chestertown | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number
231 Richard Drive | | | | 10f. Zip Code
21620 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
House Painter | | | | 16b. Kind of Business/Industry
Home Maintenance | | | |
| | 17. Father's Name (First, Middle, Last)
Alvin Ernest Whaley | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Clara Estling | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
William Franklin Whaley/Son | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8420 Bakers Lane, Chestertown, MD 21620 | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Cremation Center, LLC | | | 20c. Location - City or Town, State
Stevensville, MD | | | | |
| | 21. Signature of Funeral Service Licensee
<i>Frank J. Helfenbein</i> | | | | | 22. Name and Address of Facility
Helfenbein & Newman Funeral Home, P.A.
130 Speer Road, Chestertown, Maryland 21620 | | | | |
| | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <i>Acute myocardial infarction</i>
Due to (or as a consequence of):
b. <i>Diabetes mellitus</i>
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death
30 min | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of certifier
<i>John C. Seymour</i> | | 29c. License number
D-13824 | | 29d. Date signed (Month, Day, Year)
5-17-99 | | | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John C. Seymour, 122 Speer Road, Suite 5, Chestertown, MD 21620 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 17 1999 | | | | | 32. Registrar's Signature
<i>B. Sparks</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

WILLIAM T. YIM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17558

| | | | | | | | | |
|--|---|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HANNAH M. WATERS | | | | 2. Date of Death
Month Day Year
MAY 16, 1999 | | 3. Time of Death
1728 | |
| | 4a. Facility Name (If not institution, give street and number)
SHADY GROVE ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death
ROCKVILLE | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
577-38-2428 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
71 Yrs. | | 8. Date of Birth (Month, Day, Year)
Aug. 15, 1927 | |
| | 9. Birthplace (State or Foreign)
Maryland | | 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Gaithersburg | |
| 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
431 Muddy Branch Rd., #104 | | 10f. Zip Code
20878 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Admin. Assistant | | 16b. Kind of Business/Industry
Naval Medical Center | | 17. Father's Name (First, Middle, Last)
Wesley F. Posey | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Mary Moore | | 19a. Informant's Name/Relationship (Type, Print)
Rosa W. Brooks (Daughter) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
38 Running Brook Dr., Baltimore, MD 21244 | | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Brooke Grove Cem. | | 20c. Date
5/21/99 | | 20d. Location - City or Town, State
Laytonsville, MD | | 21. Signature of Funeral Service Licensee
<i>George R. Snowden</i> | | |
| 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Acute Myocardial Infarction
Due to (or as a consequence of):

f. Coronary Artery Disease
Due to (or as a consequence of):

g.
Due to (or as a consequence of):

h.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death

Hours

Years | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)

28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>William Dooley</i> | | 29c. License number
D33261 | | 29d. Date signed (Month, Day, Year)
May 16, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William Dooley, M. D. 9901 Medical Center Dr., Rockville, MD 20850 | | 31. Date filed (Month, Day, Year)
MAY 18 1999 | | 32. Registrar's Signature
<i>Barbara B. Sparks</i> | | | | |

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17559

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Philip Richard Waugaman

2. Date of Death

May 14, 1999

3. Time of Death

6:30 AM

4a. Facility Name (If not institution, give street and number)

723 Anderson Avenue

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

013-20-1669

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Aug. 30, 1926

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

723 Anderson Avenue

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Architectural Engineer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Charles Waugaman

18. Mother's Name (First, Middle, Maiden Surname)

Edla Rittery

19a. Informant's Name/Relationship (Type, Print)

Eileen G. Thompson (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as 10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

5-15-99

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Eileen G. Thompson

22. Name and Address of Facility

Rapp Funeral Services, P. A.

933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Ischemic Cardiomyopathy

Approximate Interval Between Onset and Death

5 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

End Stage Renal Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Raymond A. Bass

29c. License number

D21340

29d. Date signed (Month, Day, Year)

May 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raymond A. Bass, M.D., 3941 Ferrara Drive, Wheaton, MD 20906

31. Date filed (Month, Day, Year)

MAY 17 1999

32. Registrar's Signature

Raymond A. Bass

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROLAND LEE WEEKS

2. Date of Death

MAY 17, 1999

3. Time of Death

9:00 P.M.

4a. Facility Name (If not institution, give street and number)

MARINER HEALTH CARE OF SILVER SPRING

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

131-03-0118

6. Sex

M 2 F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

APRIL 2, 1909

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

422 MANSFIELD ROAD

10f. Zip Code

20910

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates: 1942-1963

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

U.S. ARMY OFFICER-LTCOL.

16b. Kind of Business/Industry

U.S. ARMED FORCES

17. Father's Name (First, Middle, Last)

CHARLES L. WEEKS

18. Mother's Name (First, Middle, Maiden Surname)

MILDRED TWILGER

19a. Informant's Name/Relationship (Type, Print)

ANNIE R. WEEKS/SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

422 MANSFIELD RD. SILVER SPRING, MD 20910

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON NATIONAL CEM.

Date

6/2/99

20c. Location - City or Town, State

ARLINGTON, VIRGINIA

21. Signature of Funeral Service Licensee

Alamy Donnell

22. Name and Address of Facility

HINES-RINALDI FUNERAL HOME, INC.
11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Secretion

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: X Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician

2 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Barbara

29c. License number

D09874

29d. Date signed (Month, Day, Year)

5/21/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BARRY ROSENBAUM 3720 FARRAGUT AVE. KENSINGTON, MD 20895

State
Registrar

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17561

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|---|---|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)
Jeanne Alice Williams | | | | 2. Date of Death
Month Day Year
May 12, 1999 | | 3. Time of Death
11:25 AM | |
| 4a. Facility Name (If not institution, give street and number)
Suburban Hospital | | | | 4b. City, Town, or Location of Death
Bethesda | | 4c. County of Death
Montgomery | |
| 5. Social Security Number
354-16-6037 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
73 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Oct. 18, 1925 | |
| 9. Birthplace (State or Foreign Country)
Illinois | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Bethesda | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
6405 Tone Drive | | | | 10f. Zip Code
20817 | | 10g. Citizen of What Country?
United States | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Teacher | | 16b. Kind of Business/Industry
Education | |
| 17. Father's Name (First, Middle, Last)
George Ostby | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Esther Anna Newquist | | | |
| 19a. Informant's Name/Relationship (Type, Print)
David O. Williams/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5049 Bradley Blvd.#5, Chevy Chase, Maryland 20815 | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery Crematorium, Inc. | | Date
May 18, 1999 | | 20c. Location - City or Town, State
Bethesda, Maryland | |
| 21. Signature of Funeral Service Licensee
<i>Robert A. Pumphrey</i> M00198 | | | | 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.
7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <i>Intraabdominal hemorrhage</i>
Due to (or as a consequence of):
b. <i>Ruptured abdominal aortic aneurysm</i>
Due to (or as a consequence of):
c. <i>Atherosclerosis, generalized</i>
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier
<i>Jewell McCallister MD</i> | | | | 29c. License number
D05256 | | 29d. Date signed (Month, Day, Year)
May 14 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LEWIS N CAHILL MD 6000 EXECUTIVE BLVD, ROCKVILLE MD 20852 | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 18 1999 | | | | 32. Registrar's Signature
<i>Jewell B. Sparks</i> | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

14

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17562

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY C. WILLIAMS

2. Date of Death

Month Day Year
MAY 16, 1999

3. Time of Death

11:24 AM

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

243-46-6734

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Apr. 1, 1921

9. Birthplace (State or Foreign Country)

N. Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

805 N. Stonestreet Ave.

10f. Zip Code

20850

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Quince Cotton

18. Mother's Name (First, Middle, Maiden Surname)

Florlen Hocutt

19a. Informant's Name/Relationship (Type, Print)

Annie Prather (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

240 M St., SW., Washington, DC 20024

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cem.

Date

5/21/99

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Brady rhythmia
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

30 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary artery disease
Due to (or as a consequence of):

10 y.

c. congestive heart failure
Due to (or as a consequence of):

6 mth

d. hypertension

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

anemia

end stage renal disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D23091

29d. Date signed (Month, Day, Year)

5/17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raldun NOSSULI 4915 Auburn Ave, Bethesda, MD 20814

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17563

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ABRAHAM

WIREKO

2. Date of Death

Month
MAY 13,Day
1999

Year

3. Time of Death

5:57AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

5333 85TH AVE. APT.201

4b. City, Town, or Location of Death

NEW CARROLLTON

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

N/A

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

59

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
OCT. 17, 1939

9. Birthplace (State or Foreign Country)

GHANA

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

NEW CARROLLTON

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

5333 85TH AVENUE APT. 201

10f. Zip Code

20784

10g. Citizen of What Country?

GHANA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

ENGINEER

16b. Kind of Business/Industry

GHANA ARMED FORCES

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

ATTAA-BOTA

19a. Informant's Name/Relationship (Type, Print)

ANNA ADUMAHAH/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5333 85TH AVE. APT. 201 NEW CARROLLTON, MD 20784

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GATE OF HEAVEN

Date

6/19/99

20c. Location - City or Town, State

SILVER SPRING, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HINES-RINALDI FUNERAL HOME, INC.

11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

CANCER OF LIVER

Approximate
Interval Between
Onset and Death

6 MONTHS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GASTROINTESTINAL BLEED

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
Investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D42580

29d. Date signed (Month, Day, Year)

5-14-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PARMITA AGUIA, MD
5632 Annapolis Rd. #13 BLADENSBURG, MD 20710

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17564

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Caroline C. Wilson

2. Date of Death

05 Day

07 Year

9.15 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Dorchester General Hospital

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

220-10-6445

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 4, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Hurlock

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4351 Cabin Creek Road

10f. Zip Code

21643

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
Black15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
4

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Line Worker

16b. Kind of Business/Industry

Acme Market Cannery

17. Father's Name (First, Middle, Last)

Alfred

Camper

18. Mother's Name (First, Middle, Maiden Surname)

Lillie

Ann

Jenkins

19a. Informant's Name/Relationship (Type, Print)

Mary Thomas (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4351 Cabin Creek Rd., Hurlock, Maryland 21643

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Thompsons town Cemetery

Date

5/12/99

20c. Location - City or Town, State

Thompsons town, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bennie Smith Funeral Home
PO Box 1687, Easton, Maryland 2160123a. Part I. Underline the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Bilateral Bronchopneumonia

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Old CVA, Alzheimer Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eyup Tanman M.D. 15 Franklin St. Cambridge, MD 21613

31. Date filed (Month, Day, Year)

MAY 10 1999

32. Registrar's Signature

Bennie B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

YAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17565

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LEWIS ELLIOT WILLIAMS, JR.

2. Date of Death

Month
MAYDay
7Year
1999

3. Time of Death

7:33AM

4a. Facility Name (If not institution, give street and number)

THE MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

5. Social Security Number

218-12-3815

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year
APR. 22, 1919

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

QUEEN ANNE'S

10c. City, Town or Location

STEVENSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

315 SOUTH LAKE DRIVE

10f. Zip Code

21666

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:
WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4or 5+)
4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MECHANICAL ENGINEER

16b. Kind of Business/Industry

AVIATION

17. Father's Name (First, Middle, Last)

LEWIS E. WILLIAMS, SR.

18. Mother's Name (First, Middle, Maiden Surname)

MAUDE E. NORRIS

19a. Informant's Name/Relationship (Type, Print)

PRISCILLA M. WILLIAMS/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

315 S. LAKE DRIVE STEVENSVILLE, MD. 21666

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREM. CTR.

Date

5-9-1999 CHESTER, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph M. Ostrowski

22. Name and Address of Facility

FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME
200 S. HARRISON ST. EASTON, MD. 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Myocardial infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

5 yrs

c. Diabetes Mellitus

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEVERE PERIPHERAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. Bruce Helmsly M.D.

29c. License number

D0053236

29d. Date signed (Month, Day, Year)

05.07.99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. BRUCE HELMSLY, M.D. 403 MARVEL CT. EASTON, MD. 21601

31. Date filed (Month, Day, Year)

MAY 10 1999

32. Registrar's Signature

R. Bruce Helmsly

WILLIAMS, LEWIS

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

U. S. DEPARTMENT OF AGRICULTURE

WATER RESOURCES DIVISION

WASHINGTON, D. C. 20250

TO: DIRECTOR, ARMY CORPS OF ENGINEERS

WASHINGTON, D. C. 20315

FROM: SAC, NEW YORK

DATE: 10/1/68

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17566

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Veronica

Young

2. Date of Death

Month Day Year
m 17 16 1999

3. Time of Death

09:47 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

215-60-8084

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 13, 1949

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4720 Boiling Brook Parkway

10f. Zip Code

20852

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Office Clerk

16b. Kind of Business/Industry

State of Maryland

17. Father's Name (First, Middle, Last)

Carlos

Sarzo

18. Mother's Name (First, Middle, Maiden Surname)

Lisa

Quintela

19a. Informant's Name/Relationship (Type, Print)

Carl Sarzo (brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8118 Felbrigg Hall Rd. Glenn Dale, MD 20769

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery 5/20/1999 Silver Spring, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiomyopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, lecture, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jeanne P. Asher MD

29c. License number

D34032

29d. Date signed (Month, Day, Year)

MAY 18 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeanne P. Asher MD 3720 FARAGUT AVE Kensington MD 20895

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

Geneva B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17567

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Florence R. Asbury

2. Date of Death

Month
May

Day
31

Year
1999

3. Time of Death

1207AM

4a. Facility Name (If not institution, give street and number)

Deaton University of Maryland Medicine

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

214-14-0237

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

07-15-09

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

611 South Charles Street

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married

☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th Grade

College (1-4or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

other people homes

17. Father's Name (First, Middle, Last)

James Mitchell

18. Mother's Name (First, Middle, Maiden Surname)

Martha Miller

19a. Informant's Name/Relationship (Type, Print)

Harold Asbury

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1509 Kennewick Road Baltimore, MD. 21218

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Westview Cemetery 06-05-99 Catonsville, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

Due to (or as a consequence of):

Stroke

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

2 days

10 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☒ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural

☐ Accident

☐ Suicide

☐ Homicide

☐ Pending investigation

☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

MD D38675

29d. Date signed (Month, Day, Year)

6/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUDITH MESHULAM 1147 S HANOVER ST BALTIMORE MD 21230

31. Date filed (Month, Day, Year)

JUN - 2 1999

32. Registrar's Signature

[Signature]

State
Registrar

Florence R. Julia Asbury
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

AM 6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item #17 per FH g772 6/2/99 EW

Certificate of Death

Reg. No.

99 17568

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Brittingham

2. Date of Death

MAY 30 1999

3. Time of Death

2307

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral
Director

5. Social Security Number

219-28-5690

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12-27-32

9. Birthplace (State or Foreign Country)

VA.

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

401 East 25th Street

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

John Brittingham

Lonnie Wheeler

18. Mother's Name (First, Middle, Maiden Surname)

Edith Gray

19a. Informant's Name/Relationship (Type, Print)

Joann Brittingham-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2203 Guilford Ave. Balto. Md.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Park

Date

6-5-99

20c. Location - City or Town, State

Balto. Md.

21. Signature of Funeral Service Licensee

Jeff Miller

22. Name and Address of Facility

Jeff Miller P.C. Funeral Home & Services
1639 N. Broadway Balto. Md. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

H/o SUBDURAL HAEMATOMA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jaaneen Salehami

29c. License number

D28595

29d. Date signed (Month, Day, Year)

5/31/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IASNEEM LAKSHMI, 7220 PARK HEIGHTS AVE BALTO MD

31. Date filed (Month, Day, Year)

JUN - 2 1999

32. Registrar's Signature

B. Jones

2120 P

State
RegistrarPatient Known as: Helen Brittingham
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

A/H 4

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

2. The second part of the paper is devoted to a discussion of the specific properties of the atom. It is shown that the specific properties of the atom are determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

3. The third part of the paper is devoted to a discussion of the applications of the theory of the structure of the atom. It is shown that the theory of the structure of the atom has many important applications, and that the laws of quantum mechanics are in agreement with the experimental facts.

ADH
ARTHUR BEASLEY
99-2276-043

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17569

AMENDED ITEM #4c PER M.D. G772 6/2/99 AH

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at 410-386-6000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | | | | | |
|---|--|--|---|--|--------------------------------|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
Arthur Beasley | | | | 2. Date of Death
Month Day Year
APRIL 19, 1999 | | | | 3. Time of Death
1455 PM | | | |
| 4a. Facility Name (If not institution, give street and number)
MARYLAND CORRECTIONAL INSTITUTE | | | | 4b. City, Town, or Location of Death
HAGERSTOWN | | | | 4c. County of Death
WASHINGTON | | | |
| 5. Social Security Number
unknown | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
54 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
May 20, 1945 | | 9. Birthplace (State or Foreign Country)
Virginia | | | |
| Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Washington | | 10c. City, Town or Location
Hagerstown | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
18601 Roxbury Drive | | | | 10f. Zip Code
21740 | | | | 10g. Citizen of What Country?
U.S.A. | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: black | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
unknown | | | | 16b. Kind of Business/Industry
unknown | | | |
| 17. Father's Name (First, Middle, Last)
Arthur Beasley Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lucille Hubbard | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Joe Hubbard/brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 106, Owings Mills, MD | | | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Date | | | | 20c. Location - City or Town, State | | | | | |
| 21. Signature of Funeral Service Licensee
Ronald S. Wade, Director | | | | 22. Name and Address of Facility
State Anatomy Board, 655 W. Baltimore Street
Baltimore, MD 21201 | | | | | | | |
| 23a. (Part I). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <u>Arteriosclerotic cardiovascular disease</u>
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Print only)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
J. ALAN LOCKE, MD | | | | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
APRIL 20, 1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. ALAN LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
APR 21 1999 | | | | 32. Registrar's Signature
B. Sparks | | | | | | | |

State
Registrar

Wash. D.C. 20540

000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17570

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

MELVIN SYLVESTER BAILEY

2. Date of Death

MAY 29 1999

Day

Year

3. Time of Death

4:30 AM

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A.

5. Social Security Number

213-34-0810

6. Sex

M 20 F

7. Age (In yrs. last birthday)

59

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN. 22, 1940

9. Birthplace (State or Foreign Country)

V.A.

Usual Residence of Decedent

10a. State

md.

10b. County

N/A.

10c. City, Town or Location

BALTO. MD.

10d. Inside City Limits

X Yes 2 No

10e. Street and Number

6609 EASTERN PARKWAY

10f. Zip Code

21214

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 X Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

N/A.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Retired - Both - Steel

16b. Kind of Business/Industry

N/A.

17. Father's Name (First, Middle, Last)

William Bailey

18. Mother's Name (First, Middle, Maiden Surname)

Hazel Rogers

19a. Informant's Name/Relationship (Type, Print)

Carol Bailey

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6609 EASTERN PARKWAY BALTO. MD. 21214

20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Manor PK 6-4-99 Arbutus, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Patricia Bitt

22. Name and Address of Facility

Bett's Funeral Home
1129 N. Caroline ST. BALTO. MD. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cardiac Arrest

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

Sepsis

c. Due to (or as a consequence of):

Obstructive Uropathy

d. Due to (or as a consequence of):

Diabetes Mellitus

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Gastrointestinal bleeding

Anemia

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 X Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Motti Mulleta MD

29c. License number

D0053586

29d. Date signed (Month, Day, Year)

MAY 29 / 1999

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

431 N. Armstead St Apt #404 Alexandria VA 22312

31. Date filed (Month, Day, Year)

JUN - 2 1999

32. Physician's Signature

Motti Mulleta

State Registrar

Baltimore, Maryland 21215-0020

Baltimore, Maryland 21215-0020
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/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17571

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Louis Bowman

2. Date of Death
Month Day Year

May 25, 1999

3. Time of Death

07:30 pm

4a. Facility Name (If not institution, give street and number)

4713 Dartford Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

212-32-5949

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

62

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Jan. 11, 1937

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

Md.

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4713 Dartford Avenue

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th Grade

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Sky Cap

16b. Kind of Business/Industry

Huntleigh Corp.

17. Father's Name (First, Middle, Last)

William R. Bowman

18. Mother's Name (First, Middle, Maiden Surname)

Ethel M. Powe

19a. Informant's Name/Relationship (Type, Print)

Odessa Y. Bowman

wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4713 Dartford Avenue Baltimore, Md. 21229

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arbutus Memorial Park

Date

June 1

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Nutter Funeral Homes, Inc.
2501 Gwynns Falls PKWY Baltimore, Md. 21216Physician
/Medical
Examiner23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death3 weeksSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. END STAGE RENAL FAILURE

Due to (or as a consequence of):

10 YEARSc. SEVERE NEPHROSCLEROSIS

Due to (or as a consequence of):

15 YEARS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA OF CHRONIC DISORDERS
CHRONIC OBSTRUCTIVE PULMONARY
DISEASE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☒ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐
☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.M. MACHIRAN, M.D. 720 CHAIDEN DRIVE LA., CATONSVILLE, 21228

31. Date filed (Month, Day, Year)

JUN 02 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17572

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ELEANOR BARCZAK | | | | 2. Date of Death
Month Day Year
MAY 29 1999 | | 3. Time of Death
3:00 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
SALISBURY CENTER: GENESIS ELDERCARE | | | | 4b. City, Town, or Location of Death
SALISBURY | | 4c. County of Death
WICOMICO | | |
| Funeral
Director | 5. Social Security Number
123-03-5970 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
88 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 30, 1911 | | |
| | 9. Birthplace (State or Foreign Country)
Delaware | | 10a. State
MD | | 10b. County
Worcester | | 10c. City, Town or Location
Berlin | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
26 Breezeway Lane | | 10f. Zip Code
21811 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | 17. Father's Name (First, Middle, Last)
Bronislaw Gregorek | | 18. Mother's Name (First, Middle, Maiden Summa)
Alexandra Moniewski | |
| 19a. Informant's Name/Relationship (Type, Print)
Bernard G. Barczak (Son) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13326 Springwood Court, Ellicott City, MD 21042 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Stanislaus Cemetery | | 20c. Location - City or Town, State
6/3/99 Baltimore, Maryland | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Witzke Funeral Homes, Inc.
5555 Twin Knolls Road, Columbia, Maryland 21045 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

e. coronary artery disease
Due to (or as a consequence of):
f. peripheral vascular
Due to (or as a consequence of):
g.
Due to (or as a consequence of):
h.
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
yes
yes | | | |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
atrial fibrillation
hypertension | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year)
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | |
| 29c. License number
029349 | | 29d. Date signed (Month, Day, Year)
5/30/99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. WILLIAM ROBBINS 200 CIVIC AVE. SALISBURY, MD. 21804 | | 31. Date filed (Month, Day, Year)
JUN 02 1999 | | 32. Registrar's Signature
 | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17573

| | | | | | | | | | | |
|--|---|--|--|---|---|---|--------------------------------|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DOROTHY BURCH | | | | 2. Date of Death
Month MAY Day 29 Year 1999 | | | | 3. Time of Death
8:10 AM | |
| | 4a. Facility Name (If not institution, give street and number)
OAKCREST VILLAGE CARE CENTER | | | | 4b. City, Town, or Location of Death
BALTO. | | | | 4c. County of Death
BALTO. | |
| Funeral
Director | 5. Social Security Number
218-05-0213 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
81 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| | 8. Date of Birth (Month, Day, Year)
Dec. 15, 1917 | | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
4316 Parkwood Avenue | | 10f. Zip Code
21206 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Medical Secretary | | 16b. Kind of Business/Industry
Medical | | 17. Father's Name (First, Middle, Last)
John August Henry Gerkens | | 18. Mother's Name (First, Middle, Maiden Surname)
Anna Dorothea Louisa Lenfer | | 19a. Informant's Name/Relationship (Type, Print)
Mr. J. Lindsey Burch / Husband | | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4316 Parkwood Avenue Balto., MD 21206 | | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. | | 20c. Location - City or Town, State
6/1/99 Towson, Maryland | | 21. Signature of Funeral Service Licensee
Timothy Harman | | |
| 22. Name and Address of Facility
Leonard J. Ruck, Inc. Funeral Home
5305 Harford Road Baltimore, MD 21214 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Upper Gastrointestinal Bleeding
peptic ulcer Disease | | Approximate Interval Between Onset and Death
1 Hour
Months | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | |
| 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Fredrick Sickis M.D. | | 29c. License number
D22645 | | 29d. Date signed (Month, Day, Year)
5/30/99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FREDRICK SICKIS M.D. 8800 WALTHER BLVD. PARKVILLE, MD, 21234 | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | 32. Registrar's Signature
[Signature] | | 33. Registrar's Title
[Signature] | | 34. Registrar's Name
[Signature] | | 35. Registrar's Address
[Signature] | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17574

| | | | | | | | | | | |
|---|---|--|--------------------------|--|---|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Victor D. Butts | | | | 2. Date of Death
Month Day Year
May 30, 1999 | | | | 3. Time of Death
11:15 am | |
| | 4a. Facility Name (If not institution, give street and number)
1141 E. Northern Parkway | | | | 4b. City, Town, or Location of Death
Baltimore | | | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
095-12-7550 | | 6. Sex
1 M 2 F | | 7. Age (In yrs. last birthday)
75 Yrs. | | 8. Date of Birth (Month, Day, Year)
Nov. 26, 1923 | | 9. Birthplace (State or Foreign Country)
New York | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
1 X Yes 2 No | | |
| 10e. Street and Number
1141 E. Northern Parkway | | | | 10f. Zip Code
21239 | | | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
1 Never Married 2 Married 3 X Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 X No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Technical Engineer | | | | 16b. Kind of Business/Industry
Westinghouse Electric Corp. | | |
| 17. Father's Name (First, Middle, Last)
Victor J. Butts | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Germaine Schadt | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Barbara Butts Smith (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
425 E. Lake Avenue Baltimore, Maryland 21212 | | | | | | |
| 20a. Method of Disposition
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. | | Date
6/01/99 | | 20c. Location - City or Town, State
Towson, Maryland | | | | |
| 21. Signature of Funeral Service Licensee Michael E. Canapp
<i>Michael E. Canapp</i> | | | | 22. Name and Address of Facility
LEONARD J. RUCK, INC. Baltimore, MD 21214
5305 Harford Road | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Sudden cardiac death
Due to (or as a consequence of):
ASCD
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
HBP
Due to (or as a consequence of):

Approximate Interval Between Onset and Death
imm
X 5y
X 10y | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 X No 3 Probably 4 Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed?
1 Yes 2 X No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No | | |
| 25. Was case referred to medical examiner?
1 X Yes 2 No | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 X No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29e. Certifier (Check only one)
1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>S. Bell</i> | | | | 29c. License number
022789 | | 29d. Date signed (Month, Day, Year)
6/1/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
S. Bell 3333 N. Calvert St Baltimore | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 2 1999 | | 32. Registrar's Signature
<i>P. Sparks</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17575

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William C. Balk

2. Date of Death

June 1 1999

3. Time of Death

6:10AM

4a. Facility Name (If not institution, give street and number)

VA Maryland Health Care System

4b. City, Town, or Location of Death

Perry Point

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

216 10 6117

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 5, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

312 Harding Avenue

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: WW 213. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Driver

16b. Kind of Business/Industry

Cab Company

17. Father's Name (First, Middle, Last)

John Balk

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Kunkel

19a. Informant's Name/Relationship (Type, Print)

Rose Joyce Balk (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2055 Featherwood Drive West Jacksonville, Fla. 32233

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Oak Lawn Cemetery

Date

6/4/1999

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdziński Funeral Home PA

1407 Old Eastern Avenue Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Carcinoma of stomach

Approximate
Interval Between
Onset and Death

3 months

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

D20215

29d. Date signed (Month, Day, Year)

6/1/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Karmachandra Nair, M.D. VA Maryland health Care System Perry Point, MD 21902

31. Date filed (Month, Day, Year)

JUN 2 1999

32. Registrar's Signature

B. Sparks

State
Registrar

NAME KNOWN TO PHYSICIAN: Balk, William C

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: This law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.Physician
Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

JOHN E. HANCOCK

[Handwritten signature]

[Handwritten signature]

1860

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17576

| | | | | | |
|---|---|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
REGINALD CUNNINGHAM | | 2. Date of Death
Month Day Year
MAY 28 1999 | | 3. Time of Death
14:08 |
| | 4a. Facility Name (If not institution, give street and number)
JOHNS HOPKINS HOSPITAL | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
216-84-2684 | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
35 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
MARCH 14, 1964 | | 9. Birthplace (State or Foreign Country)
MD. | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State
md. | | 10b. County
N/A |
| | 10c. City, Town or Location
BALTO. md. | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
1303 N. LAKEWOOD AVE | | 10f. Zip Code
21213 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) N/A | | |
| Physician
/Medical
Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Nursing Home Housekeeping N/A | | 16b. Kind of Business/Industry | | |
| | 17. Father's Name (First, Middle, Last)
John Cunningham | | 18. Mother's Name (First, Middle, Maiden Surname)
Bernice Ashc | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Bernice Cunningham | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1303 LAKEWOOD AVE BALTO. md. 21213 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
BALTO. MD. | | 20c. Location - City or Town, State
6/8/99 BALTO. MD. |
| | 21. Signature of Funeral Service Licensee
Bethesda Bots | | 22. Name and Address of Facility
Bethesda Funeral Home
1129 N. CAROLINE ST. BALTO. MD. | | |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)
a. CRYPTOCOCCAL MENINGITIS
Due to (or as a consequence of): | | | | | 1 MONTH |
| b. AIDS
Due to (or as a consequence of): | | | | | 5 YEARS |
| c. _____
Due to (or as a consequence of): | | | | | |
| d. _____
Due to (or as a consequence of): | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury
M | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
David Zaas, MD | | 29c. License number
RES-000 | | 29d. Date signed (Month, Day, Year)
MAY 28, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
DAVID ZAAS, MD, 600 N. WOLFE STREET, BALTIMORE, MARYLAND | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | 32. Registrar's Signature
David P. Sparks | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

At the time of the ... of the ...
... of the ... of the ...
... of the ... of the ...

... of the ... of the ...
... of the ... of the ...
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17577

| | | | | | | | | |
|--|---|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
VAUGHN T. CATLETT | | | | 2. Date of Death
Month MAY Day 31st Year 1999 | | 3. Time of Death
1:10 AM | |
| | 4a. Facility Name (If not Institution, give street and number)
HARBOR HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
217 50 7652 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
52 Yrs. | | 8. Date of Birth (Month, Day, Year)
FEB. 6, 1947 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Baltimore | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
8 - W. 2nd Avenue | | 10f. Zip Code
21225 | | 10g. Citizen of What Country?
U.S. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: Viet Nam | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Correctional Officer | | 16b. Kind of Business/Industry
Md. State Penitentiary | | | | |
| 17. Father's Name (First, Middle, Last)
Lloyd Catlett | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Adele Leduc | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Kimberly Catlett / Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
744 Old Riverside Road Baltimore, Maryland 21225 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Md. State Veteran Cem. | | Date
6/4/99 | | 20c. Location - City or Town, State
Crownsville, Maryland | | |
| 21. Signature of Funeral Service Licensee
<i>Donna M. Zmierski</i> | | | | 22. Name and Address of Facility
Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 21225 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Bradycardia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Coronary artery disease
Due to (or as a consequence of):

Approximate Interval Between Onset and Death
7 hours
3 weeks | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>MD Resident Housestaff</i> | | | | 29c. License number
P11949 | | 29d. Date signed (Month, Day, Year)
MAY 31st 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Abhay Moghekar, Harbor Hospital Center, 3001 South Hanover St, Baltimore | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 02 1999 | | 32. Registrar's Signature
<i>B. Sparks</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 17578

ITEMS: #108 10C PER F.H. G772 6-2-99 WR.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Leo A Davis

2. Date of Death

Month
05Day
25Year
99

3. Time of Death

02:05 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Veteran's Affairs - Baltimore, Maryland

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

5. Social Security Number

246-44-1599

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb 17, 1934

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

HARFORD

10c. City, Town or Location

Baltimore

NORTH EAST

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

108 Victoria Ct. N.E.

10f. Zip Code

21901

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Agent

16b. Kind of Business/Industry

Civil Service

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Summa)

Maggie Davis

19a. Informant's Name/Relationship (Type, Print)

Eric Davis son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

695 Caron Circle Atlanta Ga. 30318

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Cemetery

Date

6-5-1999

20c. Location - City or Town, State

Atlanta, Ga.

21. Signature of Funeral Service Licensee

Carlton C. Douglas

22. Name and Address of Facility

Douglas Funeral Service
1701 McCulloch St. Balto. Md. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Resident physician

29c. License number

P12381

29d. Date signed (Month, Day, Year)

05/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alex Chudnovsky MD 10 North Greene Street Baltimore, MD 21201

31. Date filed (Month, Day, Year)

JUN - 2 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17579

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | | | |
|--|--|---|--|--|--------------------------------|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)
Keith Dyer | | | | 2. Date of Death
Month May Day 27 Year 1999 | | | | 3. Time of Death
1:40 AM | |
| 4a. Facility Name (If not institution, give street and number)
University of Maryland | | | | 4b. City, Town, or Location of Death
Baltimore | | | | 4c. County of Death
NA | |
| 5. Social Security Number
214-64-3955 | | 8. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
41 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
07-17-57 | | 9. Birthplace (State or Foreign Country)
MD | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
1329 Milton Avenue | | | | 10f. Zip Code
21213 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th Grade Collage (1-4or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Roofer | | | 16b. Kind of Business/Industry
Roofing Company | | |
| 17. Father's Name (First, Middle, Last)
Edward A. Dyer | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Joan Quickley | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Joan D. Nelson | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4863 Greencrest Road Baltimore, MD. 21206 | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crownsville VA. Cem. | | Date
06-02-99 | | 20c. Location - City or Town, State
Crownsville, MD | | | |
| 21. Signature of Funeral Service Licensee
Bernard D. Johnson | | | | 22. Name and Address of Facility
Baltimore, Maryland 21202
WM.C. March FH 1101 E. North Avenue | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Hypercoagulable
Due to (or as a consequence of):
b. Renal failure
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Posing investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Physician <input type="checkbox"/> Medical Examiner | | 29b. Signature and title of certifier
Nancy Ar | | | | | | | |
| | | 29c. License number
P11744 | | | | 29d. Date signed (Month, Day, Year)
May 27, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NANCY ARIA University of Maryland Hospital Baltimore, MD | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | 32. Registrar's Signature
Seneca B. Sparks | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

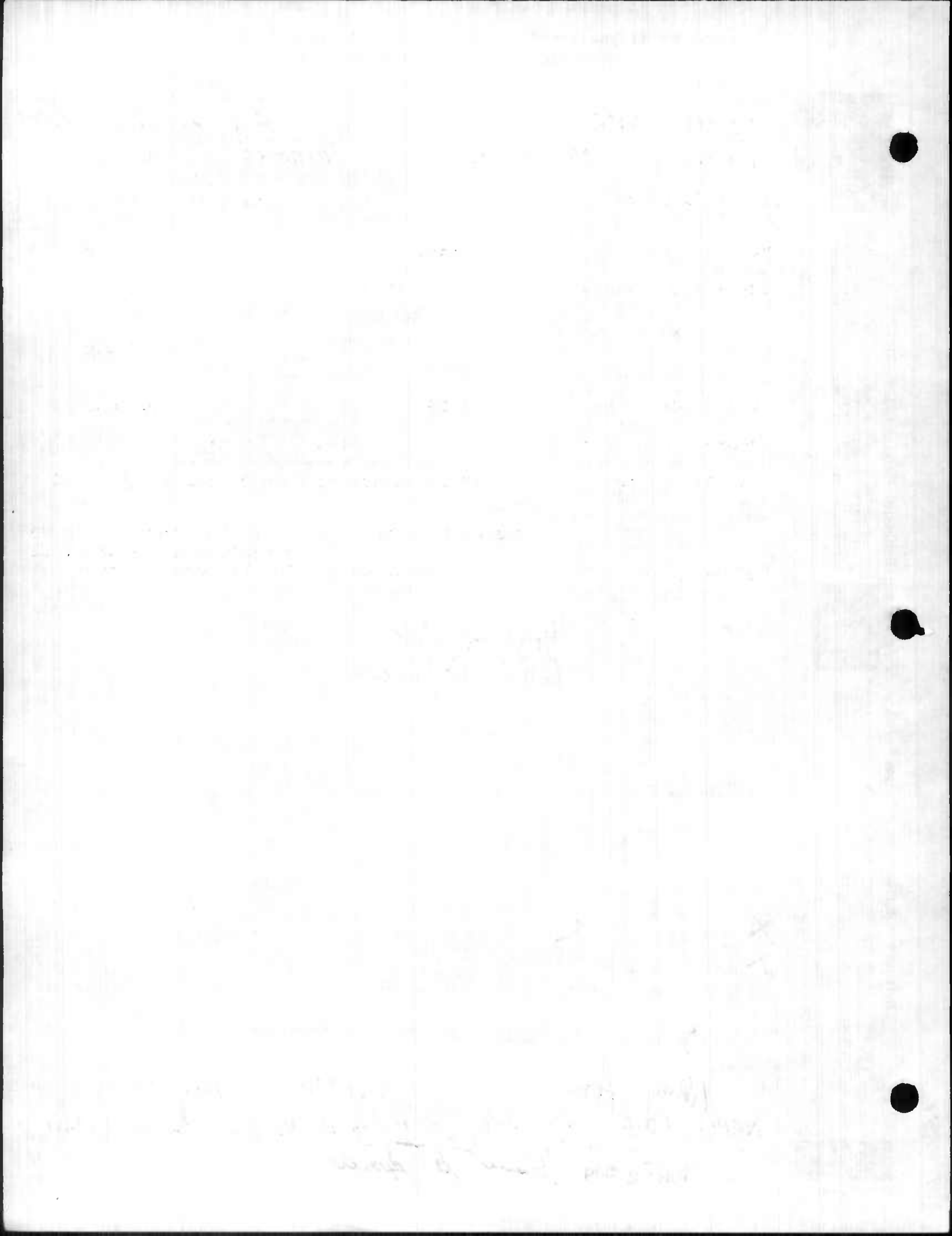
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17580

AMENDED ITEMS #4a #10e & #24a PER M.D. & FH 6/2/99 AH

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)
DONALD DEVINE | | 2. Date of Death
Month May Day 21 Year 1999 | | 3. Time of Death
15:15 PM | |
| 4a. Facility Name (If not institution, give street and number)
107 WYNDCHESTER AVENUE | | | 4b. City, Town, or Location of Death
CATONSVILLE | | 4c. County of Death
BALTIMORE |
| 5. Social Security Number
203-22-3546 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
69 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
3/26/1930 |
| 9. Birthplace (State or Foreign Country)
PENNSYLVANIA | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
MD | 10b. County
BALTIMORE | 10c. City, Town or Location
CATONSVILLE | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number
107 WYNDCHESTER AVENUE | | 10f. Zip Code
21228 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
ADMINISTRATOR | | 16b. Kind of Business/Industry
SOCIAL SECURITY | | | |
| 17. Father's Name (First, Middle, Last)
JOHN T. DEVINE | | | 18. Mother's Name (First, Middle, Maiden Surname)
EMMA (GEHRING) | | |
| 19a. Informant's Name/Relationship (Type, Print)
MYRA DEVINE (WIFE) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
107 WYNDCHESTER AVE CATONSVILLE, MD 21228 | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
BALTO. WASH. CREMATORY | | 20c. Location - City or Town, State
LAUREL, MARYLAND | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility WITZKE FUNERAL HOMES, INC.
1630 EDMONDSON AVE CATONSVILLE, MD 21228 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Alcoholic Cardiomyopathy
Due to (or as a consequence of):
b. Chronic Alcohol Abuse
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d. | | | | | Approximate Interval Between Onset and Death
5 years
20 years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atrial Fibrillation
Hypertension
Chronic Obstructive Lung Disease | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
Dr. J. S. [Signature], MD ATTENDING PHYSICIAN | | 29c. License number
Maryland D41593 | | 29d. Date signed (Month, Day, Year)
May 22, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Peter J. Slovic MD 3333 N. Calvert St Baltimore MD 21218 | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | 32. Registrar's Signature
[Signature] | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17581

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES DONNELLY

2. Date of Death

Month
06Day
01Year
99

3. Time of Death

10:28 am

4a. Facility Name (If not institution, give street and number)

Manor Health Care

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Funeral
Director

5. Social Security Number

055-09-6387

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
12-9-1913

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

13103 Miles Road

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Shipping Clerk

16b. Kind of Business/Industry

Hardware

17. Father's Name (First, Middle, Last)

John Donnelly

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Cox

19a. Informant's Name/Relationship (Type, Print)

Michael Donnelly

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

33-15 84th St., Jackson Heights, New York 11372

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

George Washington Mem. Park

6-4-99

20c. Location - City or Town, State

Paramus, New Jersey

21. Signature of Funeral Service Licensee

Gary R. DiGiovanni

22. Name and Address of Facility

Leonard J. Ruck Funeral Home Inc.
5305 Harford Rd. 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MESOTHELIOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 MONTHS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PROSTATE CANCER, CHRONIC OBSTRUCTIVE

PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Brian C. Williams

29c. License number

D31136

29d. Date signed (Month, Day, Year)

JUNE 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9101 FRANKLIN SQUARE DRIVE #321, BALTIMORE, MD 21237

31. Date filed (Month, Day, Year)

JUN - 2 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Handwritten text at the bottom of the page, possibly a signature or date.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17582

| | | | | | | | | |
|--|---|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CORINE DEVINE | | | | 2. Date of Death
Month: MAY Day: 27 Year: 1999 | | 3. Time of Death
9:35a | |
| | 4a. Facility Name (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
212-36-4326 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
89 Yrs. | | 8. Date of Birth (Month, Day, Year)
OCT, 10, 1909 | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country)
VIRGINIA | | 10. City, Town or Location
BALTIMORE CITY | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10a. State
MD. | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE CITY | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
112 ANDOVER ROAD | | | | 10f. Zip Code
21218 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: AFRO-AMERICAN | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12TH College (14 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
DOMESTIC | | 16b. Kind of Business/Industry
PRIVATE HOMES | | |
| 17. Father's Name (First, Middle, Last)
UNKNOWN | | | | 18. Mother's Name (First, Middle, Maiden Surname)
UNKNOWN | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
LORETTA GARDNER /X-DAUGHTER IN LAW | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1112 ANDOVER ROAD BALTIMORE, MD. 21218 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GREENMOUNT CREMATORY MAY 29, 1999 BALTO, MD. | | | | |
| 21. Signature of Funeral Service Licensee
<i>Calvin B. Scruggs</i> | | | | 22. Name and Address of Facility
BALTO, MD / CALVIN B. SCRUGGS FUNERAL HOME
21213 1412 E. PRESTON STREET | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p style="font-size: 2em; margin-left: 100px;">{</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 35%;"> <p>MYOCARDIAL INFARCTION</p> <p>Due to (or as a consequence of):</p> <p>Due to (or as a consequence of):</p> <p>Due to (or as a consequence of):</p> <p>Due to (or as a consequence of):</p> </div> </div> | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Mike Gibson, MD</i> | | | | 29c. License number
RES-000 | | 29d. Date signed (Month, Day, Year)
MAY 27, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MIKE GIBSON JOHNS HOPKINS HOSPITAL BALTO, MORE, MARYLAND | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | | | 32. Registrar's Signature
<i>Anna B. Sparks</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Amended Item#20b perFH G770 6/14/99 EW

99 17583

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PAULINE DAVIS

2. Date of Death

May 29 1999

3. Time of Death

1:30 PM

4a. Facility Name (If not institution, give street and number)

UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

245-20-6588

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
3-8-26

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

17 CATOR AVE.

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
-12-College (1-4or 5+)
-0-16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HEALTH ASSISTANT

16b. Kind of Business/Industry

HEALTHCARE

17. Father's Name (First, Middle, Last)

JOHN DICKENS

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

MADALYN SMITH(DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3531 DODLEY AVE. BALTIMORE, MARYLAND 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)GARDEN OF FAITH
MOUNT ZION CEMETERY

Date

6-8-99
6-7-99

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

Dorothy Hector CFS

22. Name and Address of Facility

PHILLIPS FUNERAL HOME, P.A.

1721-27 N. MONROE ST. BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

end-stage renal disease, DM, HTN

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Peter Su, MD

29c. License number

AT2438946

29d. Date signed (Month, Day, Year)

May 29, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Peter Su Union Memorial Hospital 201 E. University Pkwy Baltimore, Md

31. Date filed (Month, Day, Year)

JUN - 2 1999

32. Registrar's Signature

Benjamin G. Sparks

6/2/18

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17584

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BENJAMIN F. DEBAUFRE

2. Date of Death
Month Day Year

may 30 1999 4:50 pm

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

5. Social Security Number

212-26-6545

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

JAN 29, 1931

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE, Md.

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3104 HILLCREST AVE

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BAKER

16b. Kind of Business/Industry

BAKERY

17. Father's Name (First, Middle, Last)

BENJAMIN DEBAUFRE

18. Mother's Name (First, Middle, Maiden Summa)

KATHERINE M. LYNCH

19a. Informant's Name/Relationship (Type, Print)

ELSIE I. DEBAUFRE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3104 HILLCREST AV. BALTO Md 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MORELAND MEM.

Date

6/3/99

20c. Location - City or Town, State

BALTO. Co. Md.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

HARTLEY MILLER FUNERAL HOME CHd.
7527 HARFORD Rd. BALTO Md 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerosis Cardiovascular Disease

Approximate Interval Between Onset and Death

30 yrs

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

[Signature]

29c. License number

D33897

29d. Date signed (Month, Day, Year)

5/31/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Vissing MD. 4300 N. Charles Baltimore, MD 21218

31. Date filed (Month, Day, Year)

JUN - 2 1999

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17585

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SALVATORE D'AMICO JR.

2. Date of Death

MAY 30, 1999

3. Time of Death

0738 AM

4a. Facility Name (If not institution, give street and number)

REAR OF 451 NORTH BOULDIN STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

218-86-5980

6. Sex

M 2 F

7. Age (In yrs. last birthday)

33 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

JULY 26, 1965

9. Birthplace (State or Foreign Country)

M.D.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

3402 GOUGH ST.

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

RESTAURANT

17. Father's Name (First, Middle, Last)

SALVATORE D'AMICO SR.

18. Mother's Name (First, Middle, Maiden Surname)

TANYA PETERS

19a. Informant's Name/Relationship (Type, Print)

SALVATORE D'AMICO SR.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3402 GOUGH ST. BALTIMORE MD. 21224

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY

Date

6/4/99

20c. Location - City or Town, State

BALTIMORE MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DELLA NOCE & SONS FUNERAL HOME
322 S. HILL ST. BALTO. 21202 Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gunshot Wounds of Head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide

28a. Date of Injury

(Month, Day Year)

5-30-99

28b. Time of Injury

2:00 AM

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

subject shot

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

451 N. Bouldin St. Baltimore, Md

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

MAY 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUN 2 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-1000.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature and date: 1901 9. 10

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM EVANS

2. Date of Death

MAY 28 1999

3. Time of Death

7:30pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

3206 MILFORD AVE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

216-16-1550

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

06-22-1922

9. Birthplace (State or Foreign Country)

BALTO. MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3206 MILFORD AVE

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

BETHLAHAM STEELE

16b. Kind of Business/Industry

LABORER

17. Father's Name (First, Middle, Last)

WILLIE EVANS

18. Mother's Name (First, Middle, Maiden Summa)

LOUISE ROBINSON

19a. Informant's Name/Relationship (Type, Print)

LOUISE DAVIS (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1414 N. LINWOOD VAVE. BALTO, MD 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST

Date

6-4-99

20c. Location - City or Town, State

OWINGSMILLS, MD

21. Signature of Funeral Service licensee

[Signature]

22. Name and Address of Facility

LEROY O DYETT & SON FUNERAL HOME
4600 LIBERTY HGHTS AVE, BALTO. MD 21207

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

metastatic prostate Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D47540

29d. Date signed (Month, Day, Year)

June 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Redonda Miller, PM 7143 JHOBS, 601 N. Caroline St. Baltimore, MD 21287

31. Date filed (Month, Day, Year)

JUN - 2 1999

32. Registrar's Signature

[Signature]

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

JHM
BRENDA
ELSTON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17587

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Brenda Faye Elston

2. Date of Death

Month Day Year
MAY 29 1999

3. Time of Death

09:58 AM

4a. Facility Name (If not institution, give street and number)

NORTH WEST HOSPITAL

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

147-52-4946

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

41 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
01-29-58

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2314 E. North Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)
11th Grade

College (1-4 or 5+)
NA

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Adult Day-Care

16b. Kind of Business/Industry

Almost Family

17. Father's Name (First, Middle, Last)

James Willis McClain

18. Mother's Name (First, Middle, Maiden Summa)

Clara Bumpass

19a. Informant's Name/Relationship (Type, Print)

Cesar McClain

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

117 Caledonia Loop Columbus A.F.B., MS 39701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arbutus Mem.PK. Cem.

Date

06-04-99 Arbutus, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C.March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and Death

Immediate Cause (Final
disease or condition
resulting in death)

a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy
performed?

☒ Yes 2 ☐ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

☒ Yes 2 ☐ No

25. Was case referred to medical
examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient

2 ☒ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☒ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury
(Month, Day, Year)

5-29-99

28b. Time of
Injury

856 AM

28c. Injury at
Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

pedestrian struck by car

28f. Location (Street and Number or Rural Route Number,
City or Town, State) Live Oak & Liberty Rd
Baltimore, Md

29a. Certifier
(Check only
one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

MAY 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chutkan

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUN - 2 1999

32. Registrar's Signature

Dennis J. Chutkan

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AT 7

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17588

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sandra SARA

Eury

2. Date of Death

Month
MayDay
29Year
1999

3. Time of Death

7:45 AM.

4a. Facility Name (If not institution, give street and number)

6503 LANGDALE ROAD

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

213-14-4348

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
SEP. 24, 1920

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6503 LANGDALE ROAD

10f. Zip Code

21237

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

SALES

16b. Kind of Business/Industry

DEPARTMENT STORE

17. Father's Name (First, Middle, Last)

SAMUEL

ROSENFELD

18. Mother's Name (First, Middle, Maiden Surname)

BERTHA

(UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)

CINDY KIRBY / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

630 WARREN ROAD - COCKEYSVILLE, MD 21030

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MIKRO KODESH BETH ISRAEL

Date

5/31/99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. END Stage COPD

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Pulmonary Hypertension

Due to (or as a consequence of):

c. Coronary Artery Disease

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D 51407

29d. Date signed (Month, Day, Year)

5/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANNE MARIE FIELDS WILLS 5351 TAN KINGTON PK COLUMBIA, MD

31. Date filed (Month, Day, Year)

JUN - 2 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

8

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: #19B PER F.H. G772 6-2-99 WR.

Certificate of Death

Reg. No.

99 17589

| | | | | | | | | |
|--|--|---|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CLEMENTINE FLETCHER | | | | 2. Date of Death
Month Day Year
May 26, 1999 | | 3. Time of Death
8-35 PM | |
| | 4a. Facility Name (If not institution, give street and number)
HOWARD COUNTY GENERAL | | | | 4b. City, Town, or Location of Death
N/A | | 4c. County of Death
HOWARD | |
| Funeral
Director | 5. Social Security Number
228-42-6599 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
65 Yrs. | | 8. Date of Birth (Month, Day, Year)
01-02-34 | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country)
VA | | 10. State
MD | | 10b. County
BALTIMORE | |
| To Be Completed by Funeral Director | 10a. State | | | | 10b. County | | 10c. City, Town or Location
N/A | |
| | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
5406 MONTBEL AVENUE | | 10f. Zip Code
21207 | |
| | 10g. Citizen of What Country?
USA | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 TH GRADE College (14 or 5+) N/A | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
FACTORY WORKER | | | | 16b. Kind of Business/Industry
MD GLASS Co. | | | |
| | 17. Father's Name (First, Middle, Last)
WILLIAM OLIVER | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MARY BUNDY | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
CHARLES FLETCHER / HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5406 MONTBEL AVE. BALTO. MD. 21207 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
METRO CREMATORY | | 20c. Location - City or Town, State
5-28-99 BALTO. MD | |
| | 21. Signature of Funeral Service Licensee
Vaughn C. Greene | | | | 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
6151 BALTO. NATL PIKE, BALTO. MD. 21229 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CARDIOMYOPATHY
Due to (or as a consequence of):
b. CHRONIC RENAL FAILURE
Due to (or as a consequence of):
c. HYPERTENSION
Due to (or as a consequence of):
d. | | | | Approximate Interval Between Onset and Death
Months
Years
Years | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
N.B. Veulanki | | | | 29c. License number
D-30469 | | 29d. Date signed (Month, Day, Year)
May 27 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N.B. VEULANKI, 9055 CHEVROLET DRIVE #100, ELlicott CITY: MD. 21042 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | 32. Registrar's Signature
B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17590

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Daulton Feete

2. Date of Death

Month

Day

Year

MAY 30 1999

3. Time of Death

8:35 AM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-05-4616

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

July 8, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

800 Southerly Rd. Apt. 614 Edenwald

10f. Zip Code

21286

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner, President

16b. Kind of Business/Industry

Casket Company

17. Father's Name (First, Middle, Last)

James Marshall Feete

18. Mother's Name (First, Middle, Maiden Surname)

Mary Edna Miller

19a. Informant's Name/Relationship (Type, Print)

Frances Bright

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

906 Hillcrest Rd. Hanover, Md. 21076

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery

Date

June 3, 1999

20c. Location - City or Town, State

Pikesville, Md.

21. Signature of Funeral Service Licensee

H. J. Eckhardt

22. Name and Address of Facility

Eckhardt Funeral Chapel

11605 Reisterstown Rd. Owings Mills, Md. 21117

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ACUTE BOWEL INFARCTION

Approximate Interval Between Onset and Death

24 HOURS

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

PERIPHERAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only)

1 ☒ Medical Examiner2 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Linda F. Barr, MD

29c. License number

D35453

29d. Date signed (Month, Day, Year)

5/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINDA F. BARR M.D. 120 SISTER PIERRE DRIVE TOWSON, MARYLAND 21204

State
Registrar

31. Date filed (Month, Day, Year)

JUN 02 1999

32. Registrar's Signature

P. Sparks

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17591

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marion Gertrude Freeny

2. Date of Death

Month Day Year
May 30, 1999

3. Time of Death

8 a.m.

4a. Facility Name (If not institution, give street and number)

Sunrise Assisted Living

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard Co.

Funeral
Director

5. Social Security Number

212-40-0459

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 17, 1910

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Reisterstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11715 Reisterstown Rd.

10f. Zip Code

21136

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Board of Education

17. Father's Name (First, Middle, Last)

Joseph Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Jenny Daley

19a. Informant's Name/Relationship (Type, Print)

Carolyn Roche - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11715 Reisterstown Rd., Reisterstown, Md. 21136

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory June 1, 1999

Date

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

H. J. Eckhardt

22. Name and Address of Facility

Eckhardt Funeral Chapel

21117

11605 Reisterstown Rd., Owings Mills, Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☒ Other (Specify)

Assisted living, above

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Bruce Conger, M.D.

29c. License number

D 37013

29d. Date signed (Month, Day, Year)

June 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bruce M. Conger, M.D. 210 11055 Little Patuxent Pkwy Columbia, MD 21044

31. Date filed (Month, Day, Year)

JUN 02 1999

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

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Certificate of Death

Reg. No.

99 17592

| | | | | | | | | | | | |
|--|---|---|--|--|---|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES R. FREDERICK | | | | 2. Date of Death
Month Day Year
MAY 28, 1999 | | | | 3. Time of Death
1736 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
10 STONE MANOR COURT | | | | 4b. City, Town, or Location of Death
TOWSON | | | | 4c. County of Death
BALTIMORE | | |
| Funeral
Director | 5. Social Security Number
215-32-4686 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
66 Yrs. | | 8. Date of Birth (Month, Day, Year)
01-27-1933 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
MD. | | 10b. County
BALTIMORE | | 10c. City, Town or Location
TOWSON | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
10 STONE MANOR COURT | | | | 10f. Zip Code
21204 | | | | 10g. Citizen of What Country?
U.S.A. | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: (UNK.) | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 1 YEAR | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
OWNER AND OPERATOR | | | | 16b. Kind of Business/Industry
SERVICE STATION | | | |
| 17. Father's Name (First, Middle, Last)
GEORGE W. FREDERICK, SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MARGARET MARY McFEE | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
JAMES R. FREDERICK, JR. (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
28 ALLEGHENY AVENUE, TOWSON, MARYLAND, 21204 | | | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GREEN MOUNT CREMATORY | | 20c. Location - City or Town, State
6-2-99 BALTO., MD., 21202 | | | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
HENRY W. JENKINS AND SONS COMPANY
4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown

24a. Was an autopsy performed?
INSPECTION
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
 | | | | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
MAY 29, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | 32. Registrar's Signature
 | | | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17593

| | | | | | | | | |
|--|--|--|--|--|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Leon Paul Fialkowski | | | | 2. Date of Death
Month Day Year
JUNE 1, 1999 | | 3. Time of Death
0737 AM | |
| | 4a. Facility Name (If not institution, give street and number)
317 14TH AVENUE | | | | 4b. City, Town, or Location of Death
BROOKLYN PARK | | 4c. County of Death
ANNE ARUNDEL | |
| Funeral
Director | 5. Social Security Number
215 28 0271 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
68 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 6. Date of Birth (Month, Day, Year)
July 16, 1930 | | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
317 - 14th Avenue | | | | 10f. Zip Code
21225 | | 10g. Citizen of What Country?
U.S. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (14 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Supervisor | | | 16b. Kind of Business/Industry
Koppers | |
| 17. Father's Name (First, Middle, Last)
Anthony Fialkowski | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Mazur | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Richard Fialkowski / Brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1 N. Rose Street Baltimore, Maryland 21224 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Stanislaus Cemetery | | Date
6/4/99 | | 20c. Location - City or Town, State
Baltimore, Maryland |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 21225 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
EMPHYSEMA | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
INSPECTION
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier
(Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
JUNE 1, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 6 2 1999 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17594

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edgar Walter Gulden

2. Date of Death

Month Day Year
MAY 27, 1999

3. Time of Death

11:35 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death

PERRY POINT

4c. County of Death

CECIL

5. Social Security Number

217-12-6512

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 13, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Gambrills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

922 Autumn Valley Lane

10f. Zip Code

21054

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1945-6813. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SFC

16b. Kind of Business/Industry

Enlisted US Army

17. Father's Name (First, Middle, Last)

Edgar Gulden

18. Mother's Name (First, Middle, Maiden Surname)

Gladys Merriman

19a. Informant's Name/Relationship (Type, Print)

Irma Gulden (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

922 Autumn Valley Lane, Gambrills, MD 21054

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Maryland Veterans Cem.

Date

06/01

20c. Location - City or Town, State

Crownsville, MD

21. Signature of Funeral Service Licensee

Patrick J. Arnold

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. ADULT RESPIRATORY DISTRESS SYNDROME

2 DAYS

Due to (or as a consequence of):

b. PNEUMONIA

2 DAYS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMER'S DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. Sodhi

29c. License number

D42014

29d. Date signed (Month, Day, Year)

MAY 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURINDERPAL SODHI, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902

31. Date filed (Month, Day, Year)

JUN 02 1999

32. Registrar's Signature

Geneva G. Sparks

State
RegistrarNAME KNOWN TO PHYSICIAN: GULDEN, EDGAR W.
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

LUCILLE GODSEY

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17595

| | | | | | | | | |
|--|---|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Lucille Godsey | | | | 2. Date of Death
Month: MAY Day: 25 Year: 1999 | | 3. Time of Death
9:30 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Stella Maris At Mercy Hospice | | | | 4b. City, Town, or Location of Death
Balto. | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
217-22-6668 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
79 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
09-27-19 | 9. Birthplace (State or Foreign Country)
VA |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
1 W. Conway St Apt 614 | | | | 10f. Zip Code
21201 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Collage (1-4or 5+)
Unknown | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Assembler | | | 16b. Kind of Business/Industry
Western Electric | |
| 17. Father's Name (First, Middle, Last)
Sandy Harris | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lula mise | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
LaVerne Boston Niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1139 Wedgewood Rd., Balto. MD 21229 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Park | | Date
5-29-99 | 20c. Location - City or Town, State
Randallstown, MD | |
| 21. Signature of Funeral Service Licensee
Vaughn C Green | | | | 22. Name and Address of Facility
Vaughn C Green Funeral Services
5151 Balto. Natl. Pike Balto. MD 21229 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Cardiorespiratory Arrest
Due to (or as a consequence of):
b. Endometrial Cancer
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) STELLA MARIS AT MERCY HOSPICE | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Neil B. Rosenheim | | | | 29c. License number
108372 | | 29d. Date signed (Month, Day, Year)
May 26, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Neil B. Rosenheim, 301 Saint Paul Place, Balto, Md | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | 32. Registrar's Signature
Jenna B. Sparks | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State
Registrar

445

275

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

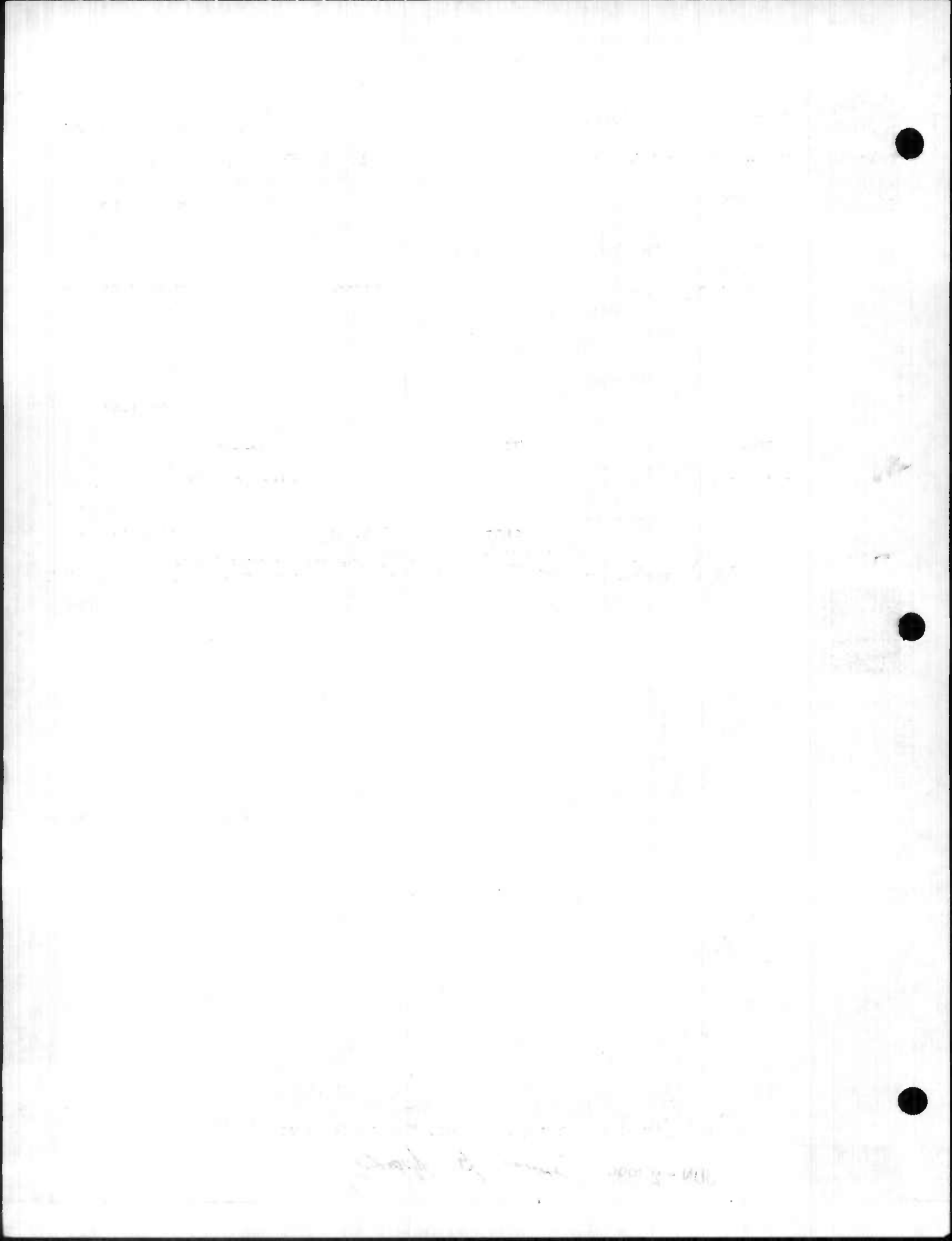
99 17596

| | | | | | | | | |
|---|--|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Clarice Giberti | | | | 2. Date of Death
Month May Day 30 Year 1999 | | 3. Time of Death
1:30am | |
| | 4a. Facility Name (If not institution, give street and number)
Manor Care Health Services | | | | 4b. City, Town, or Location of Death
Towson MD | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
013-28-2328 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
92 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 5, 1906 | |
| | 9. Birthplace (State or Foreign Country)
MA | | 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Towson | |
| To Be Completed by Funeral Director | 10d. inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
509 East Joppa Road | | 10f. Zip Code
21286 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Nurse | | 16b. Kind of Business/Industry
Medical | | | |
| | 17. Father's Name (First, Middle, Last)
James R. Carkin | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Eva Burton | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Brian Garney / Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Route 4, Box 4242 Belton TX 76513 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mount Prospect Cem. June 3, 1999 | | 20c. Location - City or Town, State
Bridgewater, MA | | | |
| | 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. | | | | 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 East Fort Avenue, Baltimore Maryland 21230 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| Physician
/Medical
Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier
 | | | | 29c. License number
142736 | | 29d. Date signed (Month, Day, Year)
5-30-99 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Ayman Akkad 509 East Joppa Road, Towson Maryland 21204 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#19a perFH G772 6/2/99 EW

Certificate of Death

Reg. No.

99 17597

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BETYA

GOLDENSHTEYN

2. Date of Death

Month Day Year

May 27, 1999

3. Time of Death

2135

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

219-35-4443

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JAN. 25, 1905

9. Birthplace (State or Foreign Country)

MOLDOVA

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

OWINGS MILLS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

439 DOE MEADOW DRIVE

10f. Zip Code

21117

10g. Citizen of What Country?

MOLDOVA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

4 YRS

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

MOISHA

GERSHONZON

18. Mother's Name (First, Middle, Maiden Surname)

MIRIAM

ZILBERSTEIN

19a. Informant's Name/Relationship (Type, Print)

IDA GROBOKOVATEL / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

439 DOE MEADOW DRIVE - OWINGS MILLS, MD 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON CHIZUK AMUNO

Date

5/30/99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

>1wk

Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Sepsis

Due to (or as a consequence of):

>1wk

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary Fibrosis

Anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

LK Bonasera

29c. License number

P12307

29d. Date signed (Month, Day, Year)

May 27, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

LK Bonasera, MD - Sinai Hospital

31. Date filed (Month, Day, Year)

JUN - 2 1999

32. Registrar's Signature

B. Sparks

State Registrar

Bettya Goldenshteyn

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

AATZ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17598

| | | | | | |
|---|--|---|---|--|------------------------------------|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
SHIRLEY GOLDFEIN | | 2. Date of Death
Month MAY Day 28 Year 1999 | | 3. Time of Death
7:46 Am |
| | 4a. Facility Name (If not institution, give street and number)
SINAI HOSPITAL OF BALTIMORE | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
216-16-2617 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
76 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
AUG 27, 1922 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
1450 BEDFORD AVE. | | 10f. Zip Code
21208 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SECRETARY | | 16b. Kind of Business/Industry
YESHIVA | |
| 17. Father's Name (First, Middle, Last)
MAX OBSTLER | | 18. Mother's Name (First, Middle, Maiden Surname)
ROSE UNKNOWN | | | |
| 19a. Informant's Name/Relationship (Type, Print)
ESTHER MARGOLESE (DAUG.) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3826 MENLO DR. BALTIMORE, MD 21215 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
BNAI ISRAEL | | 20c. Location - City or Town, State
BALTIMORE, MD | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS
Due to (or as a consequence of):
b. PNEUMONIA
Due to (or as a consequence of):
c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE
Due to (or as a consequence of):
d. | | Approximate Interval Between Onset and Death
2 WEEKS
2 MONTHS
5 YEARS | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SACRAL DECUBITUS ULCER | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
 MD | | 29c. License number
P12333 | | 29d. Date signed (Month, Day, Year)
MAY 28 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOSEPHINE OWUSU-SAKYI, 2401 BELVEDERE AVENUE, BALTIMORE, MD 21215 | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | 32. Registrar's Signature
 | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

GOLDFEIN, SHIRLEY

444

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17599

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BERTHA

GREENSTEIN

2. Date of Death

Month
MAYDay
28Year
19993. Time of Death
11 pm

4a. Facility Name (If not institution, give street and number)

HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

198-07-4993A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month

Day

Year

9. Birthplace (State or Foreign Country)

JUNE 28, 1913 PENNSYLVANIA

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6121 MONTROSE RD.

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

SAMUEL

WALLACE

18. Mother's Name (First, Middle, Maiden Surname)

SARAH

POGRABIRNSKY

19a. Informant's Name/Relationship (Type, Print)

MRS. MARLENE NEEDLEMAN (DAUG.)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12318 FLAMINGO LANE BOWIE, MD 20715

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

ROOSEVELT MEM. PARK

Date

5/30/99

20c. Location - City or Town, State

TREVOSSE, BUCKS CO., PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

DA9942

29d. Date signed (Month, Day, Year)

May 29 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORY A. COMPTON MD 6121 Montrose Rd Rockville, MD

31. Date filed (Month, Day, Year)

JUN - 2 1999

32. Registrar's Signature

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 17600

Certificate of Death

Reg. No.

AMENDED ITEM#1 PER M.D. G772 6/2/99 AH

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Harvey WILLIAM P HARVEY SR

2. Date of Death

May 29, 1999 9 58 PM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

MAYNOR CARE - Ruxton

4b. City, Town, or Location of Death

Towson

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

216-03-5847

6. Sex

188M 20 F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 2, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

BALTIMORE

10c. City, Town or Location

Monkton

10d. Inside City Limits

Yes 2 No

10e. Street and Number

17321 BIG FALLS ROAD

10f. Zip Code

21111

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

CHIEF Custodian

16b. Kind of Business/Industry

BALTIMORE COUNTY

BOARD of Education

17. Father's Name (First, Middle, Last)

Amos Harvey, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Florence Rebecca Pennington

19e. Informant's Name/Relationship (Type, Print)

William P. Harvey, Jr. son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5504 GOURANE AVE BALTIMORE MD 21212

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Dulaney Valley Memorial Park Titonium, Md

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Quay Harris

22. Name and Address of Facility

CHAIRMAN - HORRER F. H.

5240 REISTERSTOWN ROAD

BALTIMORE MD 21215

23e. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Stroke

Approximate Interval Between Onset and Death

2 Months

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24e. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending Investigation

6 Could not be determined

28e. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. P. Harris MD

29c. License number

D45475

29d. Date signed (Month, Day, Year)

6-1-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

RAHMAN MOHAMMAD REZA; SUITE 105 17 FONTANA LANE; BALTIMORE, MD 21237

31. Date filed (Month, Day, Year)

JUN - 2 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

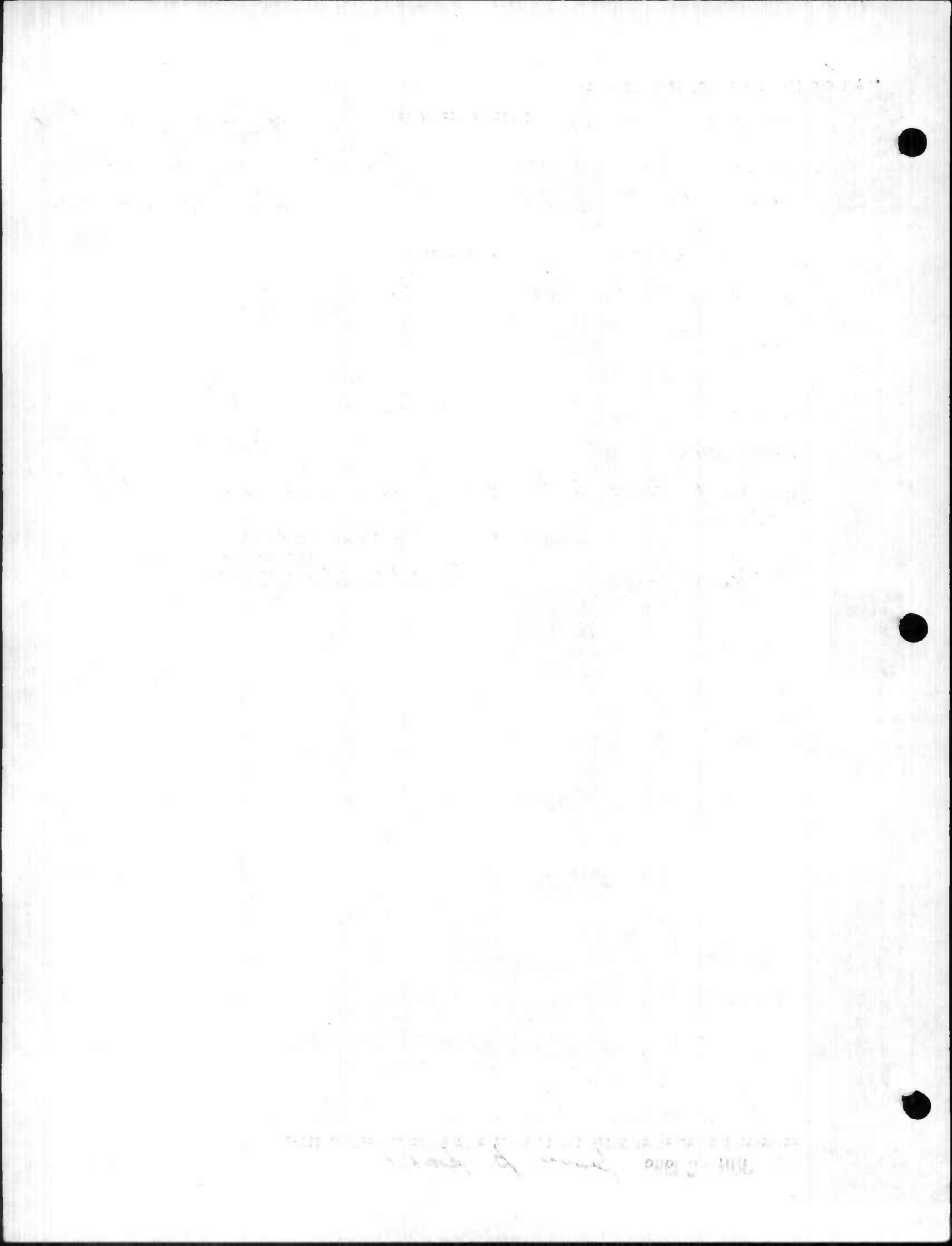
Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

AH 4



WRC
99-3046-510
SPENCER
HACK

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, 27, 28A-F PER MEO 6772 6-10-99 ^{WR} Certificate of Death

Reg. No. 99 17601

| | | | | | | | | | |
|--|---|--|---|--------------------------------|--|---|---|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
SPENCER HACK | | | | | 2. Date of Death
Month Day Year
MAY 26, 1999 | | 3. Time of Death
4:55 PM. | |
| | 4a. Facility Name (If not institution, give street and number)
SINAI HOSPITAL | | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
220-74-9099 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
31 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
2-7-68 | | 9. Birthplace (State or Foreign Country)
BAIT.O. | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
N/A | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number
3312 SUMPTER AVE | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
UNEMPLOYED | | 16b. Kind of Business/Industry
NONE | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
STANLEY HACK | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
BAFATAN BHADOOR | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
BAFATAN BHADOOR (MOTHER) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3312 SUMPTER AVE, BALTO. MD 21215 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
arbutus cemetery | | Date
6-1-99 | 20c. Location - City or Town, State
BALTO. COUNTY | | | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
LEROY O DYETT & SON FUNERAL HOME
4600 LIBERTY HGHTS AVE, BALTO. MD 21207 | | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. NARCOTIC INTOXICATION
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
5-26-99 | | 28b. Time of Injury
UNKNOWN M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
UNKNOWN |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
HOME | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3312 SUNTER AVE., BALTIMORE, MD | | | | | | |
| | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
 | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 27, 1999 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. A. Sparks, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
JUN 2 1999 | | 32. Registrar's Signature
 | | | | | | |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 17602

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|--|--|---|--|--|---|----|-------------------------|---|----|----------------------|------------------|----|---------------|----------------|----|---------------------|--------------|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Richard Hobson | | | | 2. Date of Death
Month MAY Day 30 Year 1999 | | 3. Time of Death
12:40 AM | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
FREDERICK Villa Nursing Center | | | | 4b. City, Town, or Location of Death
Catonsville | | 4c. County of Death
BALTIMORE | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
413-24-4320 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
86 Yrs. | | 8. Date of Birth (Month, Day, Year)
05-22-13 | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country)
ALABAMA | | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
911 N. WARWICK AVENUE | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
USA | | | | | | | | | | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 TH GRADE | | College (1-4 or 5+) 6 YRS | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
EDUCATION OFFICER | | 16b. Kind of Business/Industry
HEALTH, EDUCATION & WELFARE IN DC | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
RICHARD HOBSON, JR. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ALMA DAVIS | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
LAVADA HOBSON WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
911 N. WARWICK AVE., BALD. MD. 21216 | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GARRISON FOREST | | Date
6.3.99 | | 20c. Location - City or Town, State
OWINGS MILLS, MD | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
Wagner C Greene | | | | 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
5151 BALD NATL PIKE, BALD. MD. 21229 | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>BRONCHOPNEUMONIA</td> <td>Approximate interval Between Onset and Death
One week</td> </tr> <tr> <td>b.</td> <td>Renal Failure</td> <td>one month</td> </tr> <tr> <td>c.</td> <td>Stroke</td> <td>3 years</td> </tr> <tr> <td>d.</td> <td>Hypertension</td> <td>Years</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. | BRONCHOPNEUMONIA | Approximate interval Between Onset and Death
One week | b. | Renal Failure | one month | c. | Stroke | 3 years | d. | Hypertension | Years |
| | Immediate Cause (Final disease or condition resulting in death) | a. | BRONCHOPNEUMONIA | Approximate interval Between Onset and Death
One week | | | | | | | | | | | | | | | | | |
| b. | | Renal Failure | one month | | | | | | | | | | | | | | | | | | |
| c. | | Stroke | 3 years | | | | | | | | | | | | | | | | | | |
| d. | | Hypertension | Years | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
N.B. Veclanki | | 29c. License number
D-30469 | | 29d. Date signed (Month, Day, Year)
June 2nd 1999 | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N.B. VECLANKI, 9055, CHEVROLET DRIVE, #100, ELICOTT CITY, MD 21042 | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | 32. Registrar's Signature
Jessie B. Sparks | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17603

AMENDED ITEM #3 PER M.D. G 772 6/28/99 AH

| | | | | | |
|---|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LEOLA HOLMIRAN | | 2. Date of Death
Month MAY Day 19 Year 1999 | | 3. Time of Death
4pm |
| | 4a. Facility Name (If not institution, give street and number)
2924 Westwood Ave | | 4b. City, Town, or Location of Death
BALTO. MD. | | 4c. County of Death
N/A. |
| Funeral
Director | 5. Social Security Number
213-30-9949 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
90 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
OCT. 10, 1908 | | 9. Birthplace (State or Foreign Country)
S.C. | | |
| To Be Completed by Funeral Director | 10a. State
MD. | | 10b. County
N/A. | | 10c. City, Town or Location
BALTO. MD. |
| | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 10e. Street and Number
2924 Westwood Ave | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6th College (1-4or 5+) N/A. | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Domestic Work | | 16b. Kind of Business/Industry
N/A. | | | |
| 17. Father's Name (First, Middle, Last)
Hammie Robinson | | 18. Mother's Name (First, Middle, Maiden Surname)
Anna Jones | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Gaenen Redd | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3422 GAITHER RD BALTO. MD 21244 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loaden PARK Cem | | Date
5/26/99 | 20c. Location - City or Town, State
BALTO. MD. |
| 21. Signature of Funeral Service Licensee
Patricia B. Bitt | | 22. Name and Address of Facility
BETS Funeral Home
1129 N. CAROLINE ST. BALTO. MD 21203 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION (probable) IMMEDIATE
Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. _____
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d. _____ | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
In Sunshine, MD. | | 29c. License number
D15140 | 29d. Date signed (Month, Day, Year)
MAY 20, 1999 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
IAN SUNSHINE MD 6210 PK. HTS. Ave, BALTO, MD 21215 | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | 32. Registrar's Signature
B. Sparks | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

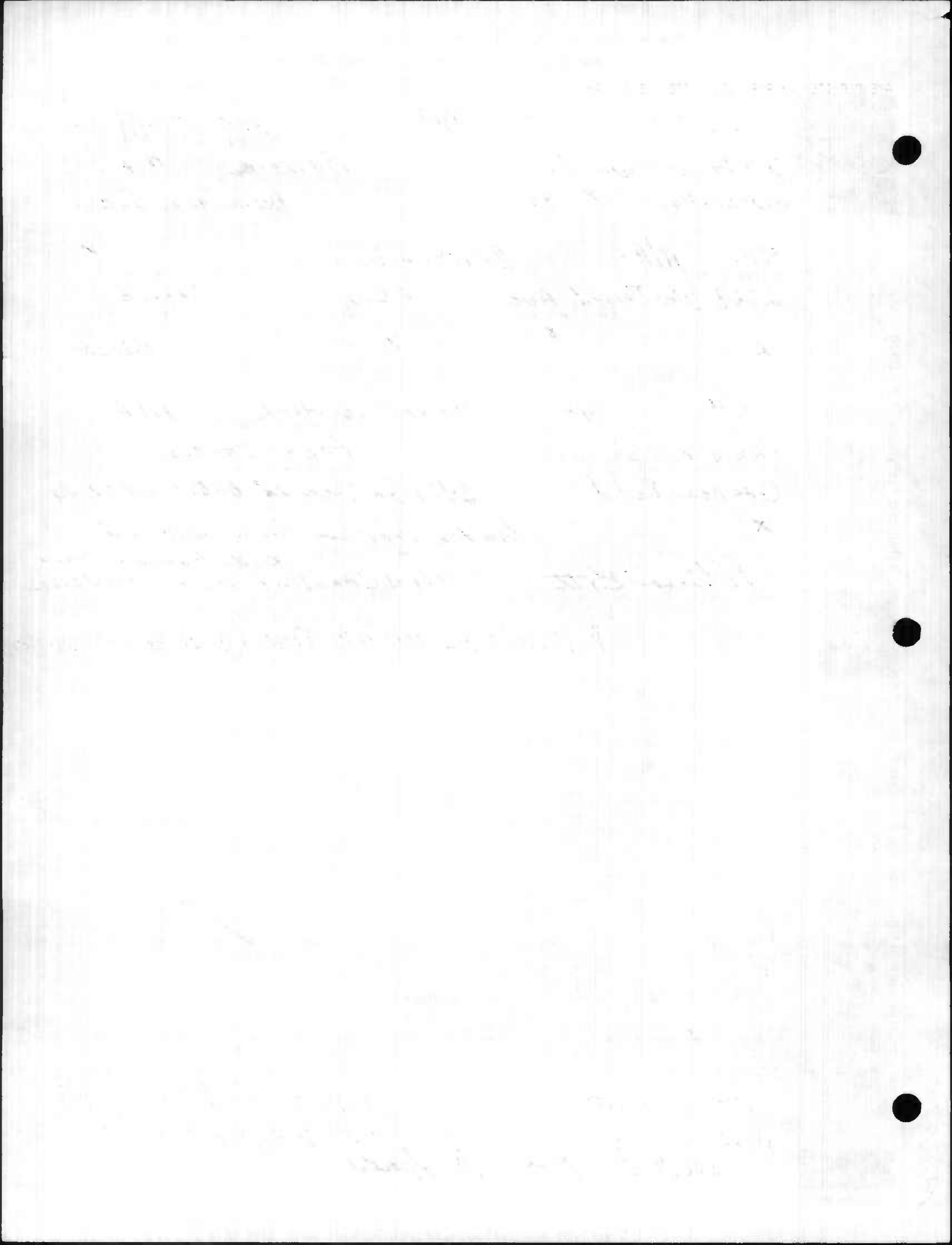
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17604

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alvin Enos Harkleroad

2. Date of Death

Month Day Year
05 29 99

3. Time of Death

0715

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

309 16 5670

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Jan. 7, 1922

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

307 - 4th Avenue

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No 1942-

If Yes, Give Year or Dates: 1963

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

1st Class Electrician

16b. Kind of Business/Industry

U.S. Navy

17. Father's Name (First, Middle, Last)

Phillip T. Harkleroad

18. Mother's Name (First, Middle, Maiden Surname)

Augusta Maria Taylor

19a. Informant's Name/Relationship (Type, Print)

Donna Andrews / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1264 Old Manchester Road Westminister, Md. 21157

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

Date

6/2/99

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

Donna M. Brancowski

22. Name and Address of Facility

Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Peritonitis

Due to (or as a consequence of):

weeks

c. Pneumonia

Due to (or as a consequence of):

weeks

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral vascular disease, renal insufficiency.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

V. Dixon King, Jr.

29c. License number

D43453

29d. Date signed (Month, Day, Year)

MAY 31, 1999

30. Name and address of person who completed certificate of death (Item 23a) (Type, Print)

V. DIXON KING, JR., MD ST. AGNES HOSPITAL, BALTIMORE, MD.

31. Date filed (Month, Day, Year)

JUN 1 02 1999

32. Registrar's Signature

Barbara B. Spauld

State Registrar

ORIGINAL

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Division of Vital Records, P.O. Box 68760,

Harkleroad, Alvin

A46

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17605

| | | | | | | | | |
|--|---|---|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ALEXANDER HUNT | | | | 2. Date of Death
Month Day Year
MAY 30 1999 | | 3. Time of Death
12:19 A | |
| | 4a. Facility Name (If not institution, give street and number)
JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
228-24-4150 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
72 Yrs. | | 8. Date of Birth (Month, Day, Year)
AUG. 19, 1926 | |
| | 9. Birthplace (State or Foreign Country)
VIRGINIA | | 10a. State
MARYLAND | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
1012 WITHERSPOON ROAD | | 10f. Zip Code
21239 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: DEC 26 / 44 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: AFRO-AMERICAN | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9TH
College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
BOILER OPERATOR | | 16b. Kind of Business/Industry
ABERDEEN IMPROVING GROUND | | | | |
| 17. Father's Name (First, Middle, Last)
ALEXANDER HUNT | | | | 18. Mother's Name (First, Middle, Maiden Surname)
RENA GERST | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
ESSIE M. HUNT / WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1012 WITHERSPOON ROAD BALTO, MD. 21239 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GREEN MOUNT CREMATORY | | Date
JUNE 2, 1999 | | 20c. Location - City or Town, State
BALTIMORE, MD. | | |
| 21. Signature of Funeral Service Licensee
<i>Calvin B. Scruggs</i> | | 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTO, MD. 21213 | | | | | | |
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Contact Gunshot Wound
Due to (or as a consequence of):

b. OF Head
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

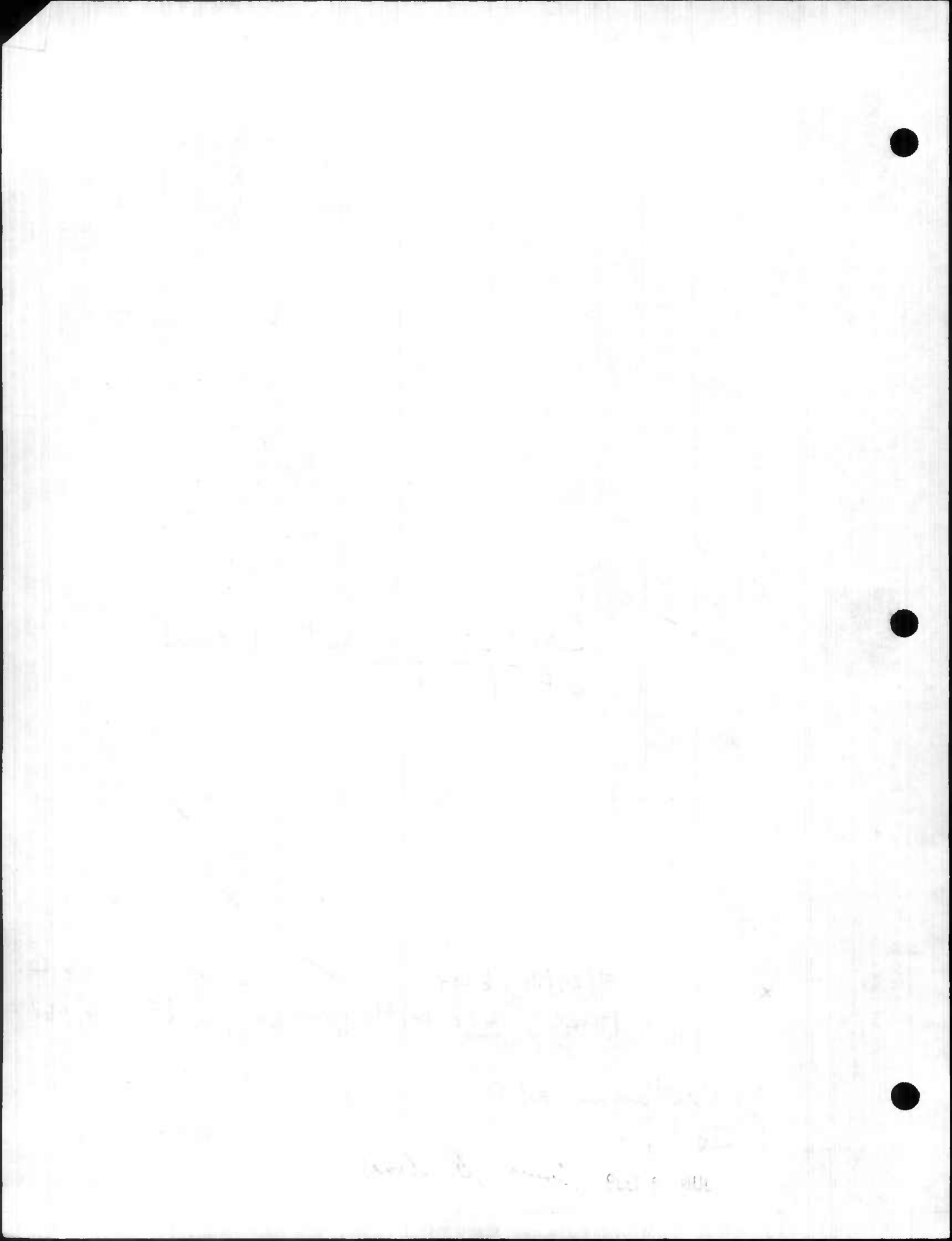
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
5/29/99 | | 28b. Time of Injury
6:08 PM | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred
Subject shot self | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Home; 1012 Witherspoon Rd; Baltimore, Md | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>Joseph Pestaner MD</i> | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
MAY 30, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | 32. Registrar's Signature
<i>James B. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AH 6

ORIGINAL



99-30860047

jhm

ROLLACE E

HEUSTESS

AMEND ITEM :4A PER MD G773 7-17-99 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17606

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rollace Evans Heustess, Jr.

2. Date of Death

MAY 29, 1999

3. Time of Death

03:37 AM

4a. Facility Name (If not institution, give street and number)

ATLANTIC CENTRAL HOSPITAL
ROUTE 90 and ROUTE 113

4b. City, Town, or Location of Death

4c. County of Death

WORCESTER

Funeral
Director

5. Social Security Number

212-21-5010

6. Sex

15 M 2 F

7. Age (In yrs. last birthday)

26 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

Aug. 26, 1972

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 Yaa 2X No

10e. Street and Number

13111 Sherwin Avenue

10f. Zip Code

21220

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 X Never Married 2 X Married
3 X Widowed 4 X Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 X Yes 2 X No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 X Yes 2 X No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Automobile Mechanic

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Rollace E. Heustess, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Patricia Heustess

19a. Informant's Name/Relationship (Type, Print)

Patricia Heustess (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13111 Sherwin Avenue, Baltimore, Maryland 21220

20a. Method of Disposition

1 X Burial 2 X Cremation 3 X Removal from State
4 X Donation 5 X Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Mem. Gardens

Date

6/2/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home, P.A.

1407 Old Eastern Avenue, Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Injuries
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 X Yaa 2 X No 3 X Probably 4 X Unknown

24a. Was an autopsy performed?

1 X Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 X No

25. Was case referred to medical examiner?

1 X Yes 2 X No

Hospital:

1 X Inpatient 2 X ER/Outpatient 3 X DOA

26. Place of Death (Check only one)

Other: 4 X Nursing Home 5 X Residence 6 X Other (Specify) SCENE

27. Manner of Death

1 X Natural 5 X Pending Investigation
2 X Accident 6 X Could not be determined
3 X Suicide 4 X Homicide

28a. Date of Injury (Month, Day, Year)

5/29/99

28b. Time of Injury

309 AM

28c. Injury at Work?

1 X Yes 2 X No

28d. Describe how injury occurred

motor vehicle accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Rt 90 Worcester Co. Md

29a. Certifier (Check only one)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Dennis J. Chute

29c. License number

OCME

29d. Date signed (Month, Day, Year)

MAY 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUN 2 1999

32. Registrar's Signature

P. Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten signature or initials in the center of the page.

Handwritten text at the bottom of the page, possibly a date or reference.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17607

| | | | | | | | | |
|--|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CHRISTOPHER JACKSON | | | | 2. Date of Death
Month Day Year
MAY 30 1999 | | 3. Time of Death
1155 | |
| | 4a. Facility Name (If not institution, give street and number)
JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
P4-64-6106 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
42 Yrs. | | 8. Date of Birth (Month, Day, Year)
02-27-57 | |
| | Usual Residence of Decedent | | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | |
| | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | | 10e. Street and Number
1508 N. PULASKI ST. | | 10f. Zip Code
21217 | | 10g. Citizen of What Country?
USA | | |
| | | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK |
| | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12TH GRADE
College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
DISABLED | | 16b. Kind of Business/Industry
N/A | | |
| | | 17. Father's Name (First, Middle, Last)
JOHN JACKSON | | 18. Mother's Name (First, Middle, Maiden Surname)
GWENDOLYN JAMES | | | | |
| | | 19a. Informant's Name/Relationship (Type, Print)
GWENDOLYN JACKSON / MOTHER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1508 N. PULASKI ST., BALTO. MD. 21217 | | | | |
| | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
KING PARK | | 20c. Location - City or Town, State
6-5-99 RANDALSTOWN, MD | | |
| | | 21. Signature of Funeral Service Licensee
Vaughn C. Greene | | 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
5151 BALTO. NAT'L PIKE, BALTO. MD. 21229 | | | | |
| | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____ | | | | | | Approximate Interval Between Onset and Death
18 HOURS |
| | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
LUPUS ERYTHEMATOSUS
ACUTE RENAL FAILURE
STAPHYLOCOCCAL BACTEREMIA | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | | 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | |
| | | 29b. Signature and title of certifier
Vaughn C. Greene, MD | | 29c. License number
RES-000 | | 29d. Date signed (Month, Day, Year)
MAY 30 1999 | | |
| | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
OLIVER BACON, TOWER 110 JOHNS HOPKINS HOSPITAL, 600 NORTHWOLFE STREET, BALTIMORE MARYLAND | | | | | | |
| | | 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | 32. Registrar's Signature
[Signature] | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17608

| | | | | | | | | |
|---|---|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ollie M. Johnson | | | | 2. Date of Death
Month Day Year
May 29, 99 | | 3. Time of Death
4:10pm | |
| | 4a. Facility Name (If not institution, give street and number)
BLUE POINT NURSING HOME | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
NA | |
| Funeral
Director | 5. Social Security Number
220-12-9798 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
92 Yrs. | | 8. Date of Birth (Month, Day, Year)
09-08-06 | |
| | 9. Birthplace (State or Foreign Country)
VA | | 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 10e. Street and Number
2525 West Belvedere Avenue | | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7th Grade
College (1-4or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Disabled | | 16b. Kind of Business/Industry
Unemployed | | | |
| | 17. Father's Name (First, Middle, Last)
Willis Harvey | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Elizee Robertson | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Dorothy E. Tucker | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17411 Kirstin Court Olney, Maryland 20832 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus Mem. Pk. Cem. | | Date
06-03-99 | | 20c. Location - City or Town, State
Arbutus, MD | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Sepsis | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
 | | 29c. License number
MD D27564 | | 29d. Date signed (Month, Day, Year)
6/11/99 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Allen, Letheman 1838 Greene Tree Rd #300 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | 32. Registrar's Signature
 | | | | | |
| | State Registrar | | | | | | | |

ORIGINAL

Handwritten signature and date: 10/10/10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17609

| | | | | | | | | |
|---|--|---|--|--|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Lillie Bell Jones | | | | 2. Date of Death
Month May Day 22 Year 1999 | | 3. Time of Death
11:35 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Maryland General Hospital | | | | 4b. City, Town, or Location of Death
Baltimore City | | 4c. County of Death
n/a | |
| Funeral
Director | 5. Social Security Number
220-12-7275 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
84 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Aug. 30, 1914 | 9. Birthplace (State or Foreign Country)
Md. |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Md. | | 10b. County
n/a | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
1204 Myrtle Avenue | | | | 10f. Zip Code
21217 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
12th Grade | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Beautician | | 16b. Kind of Business/Industry
Self-Employed | | |
| 17. Father's Name (First, Middle, Last)
Granville Dorsey | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Letitia Plummer | | | | |
| 19a. Informant's Name/Relationship (Type, Print) nephew
James E. Thomas | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1214 Myrtle Avenue Baltimore, Md. 21217 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Park | | 20c. Location - City or Town, State
May 29 Baltimore, Md. | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Nutter Funeral Homes, Inc.
2501 Gwynns Falls PKWY Baltimore, Md. 21216 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Multiple organ Failure
Due to (or as a consequence of):
b. Sepsis
Due to (or as a consequence of):
c. Multiple Decubitus ulcers & infection
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner | | 29b. Signature and title of certifier
 | | | | | | |
| | | 29c. License number
P11828 | | 29d. Date signed (Month, Day, Year)
5/22/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rasha Morad, M.D., Maryland General Hospital | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 02 1999 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17610

| | | | | | | | | | | | |
|--|--|---------------------------------|---|---|--|---------------------------------|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Pauline Jones | | | | 2. Date of Death
Month May Day 27 Year 1999 | | | | 3. Time of Death
1:00 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
Johns Hopkins Bayview Medical Center | | | | 4b. City, Town, or Location of Death
Baltimore | | | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
212-46-0799 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
93 Yrs. | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | 8. Date of Birth (Month, Day, Year)
July 20, 1905 | 9. Birthplace (State or Foreign Country)
Rhode Island | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Baltimore | 10c. City, Town or Location
Dundalk | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number
7911 Diehlwood Road | | | | 10f. Zip Code
21222 | | 10g. Citizen of What Country?
United States | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
12 Years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | | | | | |
| 17. Father's Name (First, Middle, Last)
Otto Dreher | | | | | 18. Mother's Name (First, Middle, Maiden Sumama)
Anna Martin | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Howard P. Jones/Son | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7911 Diehlwood Road Dundalk, Maryland 21222 | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery | | Data
6/1/1999 | | 20c. Location - City or Town, State
Baltimore, Maryland | | | |
| 21. Signature of Funeral Service Licensee
<i>Patricia M. Hemery</i> | | | | | 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

sepsis
Due to (or as a consequence of):

pneumonia
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death
48 hours | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>J. van Edmond MD</i> | | | | | 29c. License number
P 11339 | | | 29d. Date signed (Month, Day, Year)
May 27, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. van Edmond MD, 4940 Eastern Avenue, Baltimore, MD 21224 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | | | | 32. Registrar's Signature
<i>B. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 17611

ITEMS: #23 PART I, 27 PER MEO G772 6-9-99 WR.

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|---|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
PAULA LEE JOYCE | | | | 2. Date of Death
Month Day Year
May 26, 1999 | | 3. Time of Death
10:59 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Good Samaritan Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
219-70-0144 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
40 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
OCT. 16, 1958 | | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number
5510 MIDWOOD AVENUE | | | | 10f. Zip Code
21212 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: AFRO-AMERICAN | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10TH
College (14 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
UNEMPLOYED | | | 16b. Kind of Business/Industry
NONE | |
| 17. Father's Name (First, Middle, Last)
LAWRENCE A. JOYCE | | | | 18. Mother's Name (First, Middle, Maiden Surname)
E. RUTH PITTS | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
DORIS J. BARNES / SISTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5510 MIDWOOD AVENUE BALTO, MD 21212 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT. ZION CEMETERY | | Date
JUNE 1, 1999 | | 20c. Location - City or Town, State
BALTO, MD. | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTO, MD. 21213 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. DIABETIC KETOACIDOSIS
Due to (or as a consequence of):

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input checked="" type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
May 27, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. LARSON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 2 1999 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

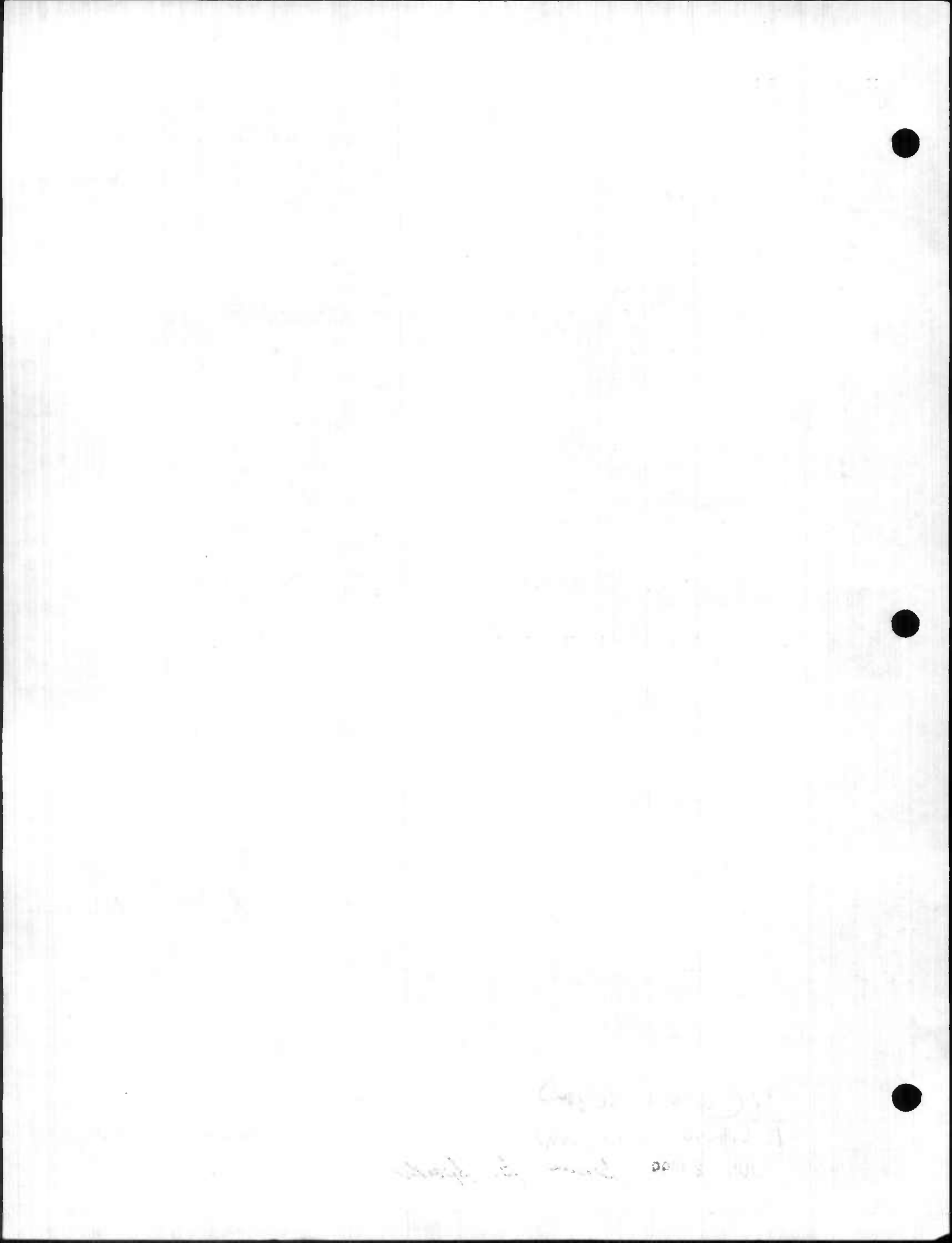
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17612

| | | | | | | | | |
|---|---|--|---|--------------------------------|---|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Margaret E. Jones</i> | | | | 2. Date of Death
Month Day Year
<i>MAY 30 1999</i> | | 3. Time of Death
<i>1115 AM</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>101 CENTER PLACE</i> | | | | 4b. City, Town, or Location of Death
<i>DUNDALK</i> | | 4c. County of Death
<i>BALTIMORE</i> | |
| Funeral
Director | 5. Social Security Number
<i>219-12-8551</i> | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>86</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>JUN 18, 1912</i> | | 9. Birthplace (State or Foreign Country)
<i>MD.</i> |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10e. State
<i>MD</i> | 10b. County
<i>BALTIMORE</i> | 10c. City, Town or Location
<i>DUNDALK, MD.</i> | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
<i>101 CENTER PLACE</i> | | | 10f. Zip Code
<i>21222</i> | | 10g. Citizen of What Country?
<i>USA</i> | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>WHITE</i> | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>6th</i> College (1-4 or 5+) <i>NA</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>HOMEMAKER</i> | | 16b. Kind of Business/Industry
<i>HOME</i> | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
<i>GEORGE REDIFER</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>LUCILLE (UNK)</i> | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>VALERIE JONES</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>2517 CUB HILL Rd. BALTO MD 21234</i> | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>OAKLAWN CEM.</i> | | Date
<i>6/30/99</i> | | 20c. Location - City or Town, State
<i>BALTO. Co. MD</i> | |
| | 21. Signature of Funeral Service Licensee
<i>Haller Miller</i> | | | | 22. Name and Address of Facility
<i>HARTLEY MILLER FUNERAL HOME, CHTD.
7527 HARFORD Rd. BALTO. MD 21234</i> | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. <i>Atherosclerotic Cardiovascular disease</i>
Due to (or as a consequence of):
b. <i>Hypertension</i>
Due to (or as a consequence of):
c. <i>Hypercholesterolemia</i>
Due to (or as a consequence of):
d. <i>Diabetes Mellitus</i> | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
<i>Edward M.D.</i> | | | | 29c. License number
<i>D21696</i> | | 29d. Date signed (Month, Day, Year)
<i>6/1/99</i> | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>1005 N. Point Blvd #224 Baltimore MD 21224 - Willanda Edwards</i> | | | | | | | |
| | 31. Date filed (Month, Day, Year)
<i>JUN - 2 1999</i> | | | | 32. Registrar's Signature
<i>G. Sparks</i> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17613

| | | | | | | | | | | |
|---|--|---------------------------------|---|--|--|---|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
SHARON KEARNEY | | | | | | 2. Date of Death
Month MAY Day 28 Year 1999 | | 3. Time of Death
3 AM | |
| | 4a. Facility Name (If not institution, give street and number)
NORTHWEST HOSPITAL CENTER | | | | | | 4b. City, Town, or Location of Death
RANDALLSTOWN | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
220-54-8176 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
50 Yrs. | | 8. Date of Birth (Month, Day, Year)
FEB. 23, 1949 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Md. | | 10b. County
Baltimore | | 10c. City, Town or Location
Reisterstown | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
228 Northway Road | | | | 10f. Zip Code
21136 | | 10g. Citizen of What Country?
U.S.A. | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Graphic Artist | | | 16b. Kind of Business/Industry
Advertising | | | |
| 17. Father's Name (First, Middle, Last)
John Edward Tracey | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Elizabeth Jane McGee | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Elizabeth J. Tracey - Mother | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
228 Northway Rd., Reisterstown, Md. 21136 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory May 28, 1999 | | | 20c. Location - City or Town, State
Baltimore, Maryland | | 20d. Date
May 28, 1999 | | |
| 21. Signature of Funeral Service Licensee
H. G. Eckhardt | | | | | | 22. Name and Address of Facility
Eckhardt Funeral Chapel
11605 Reisterstown Rd., Owings Mills, Md. 21117 | | | | |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. BREAST CANCER
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. METASTASES TO BONE & CHEST WALL.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d. | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
METASTASES TO BONE & CHEST WALL. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier
Hannah HOUSE PHYSICIAN | | | 29c. License number
D42723 | | 29d. Date signed (Month, Day, Year)
MAY 28TH 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
AVV ERAHALLI M HARISH BALTIMORE MD 21236 | | | | | | 31. Date filed (Month, Day, Year)
JUN 02 1999 | | | | |
| 32. Registrar's Signature
B. Sparks | | | | | | 33. State Registrar
MD | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

22-74-1000

20

22-74-1000

22-74-1000

22-74-1000

22-74-1000

22-74-1000

22-74-1000

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22-74-1000

22-74-1000

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22-74-1000

22-74-1000

22-74-1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17614

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary L. Kelley

2. Date of Death

Month Day Year
May 30, 99

3. Time of Death

11:40am

4a. Facility Name (If not institution, give street and number)

3603 Bonview Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

MD

Funeral
Director

5. Social Security Number

215-12-3848

6. Sex

1 ☐ M 2 ☒ F
XX

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
03-17-14

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3603 Bonview Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th Grade

College (14 or 5+)

NA

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Home-maker

16b. Kind of Business/Industry

in home

17. Father's Name (First, Middle, Last)

Birven Key

18. Mother's Name (First, Middle, Maiden Surname)

Dinah Diggs

19a. Informant's Name/Relationship (Type, Print)

George Kelley

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3603 Bonview Avenue Baltimore, Maryland 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Baltimore Cemetery 06-04-99 Baltimore, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Arteriosclerotic Cardiovascular disease*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

yes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Heart Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ch. Shy Ch

MD

29c. License number

0-18151

29d. Date signed (Month, Day, Year)

6-1-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

98 N. Broadway - Apt 410 Baltimore MD 21231

31. Date filed (Month, Day, Year)

JUN - 2 1999

32. Registrar's Signature

*James B. Sparks*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17615

| | | | | | | | | | | | | | | | | | | | |
|--|--|--|---|---------------------------------|--|--|--|---|--|--|---|--|--|--|---|----------------|---|----------------|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARY EVELYN KENNEY | | | | | | 2. Date of Death
Month Day Year
MAY 26 1999 | | 3. Time of Death
1:50pm | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
MANOR CARE TOWSON | | | | | | 4b. City, Town, or Location of Death
TOWSON | | 4c. County of Death
BALTIMORE | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
220-05-4954 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
84 Yrs. | | 8. Date of Birth (Month, Day, Year)
06/10/1914 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
TOWSON | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| | 10e. Street and Number
509 EAST JOPPA RD. | | | | 10f. Zip Code
21204 | | 10g. Citizen of What Country?
USA | | | | | | | | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12yrs. College (14 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOUSEWIFE | | | 16b. Kind of Business/Industry
HOMEMAKER | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
EDWARD WOOD | | | | | | 18. Mother's Name (First, Middle, Maiden Summa)
EDITH MILLER | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
DIANE W. CURTIS(NIECE) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
31 OLD SOUND RD. JOPPATOWN, MD. 21085. | | | | | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MORELAND MEM. PARK | | 20c. Date
05/29/99 | | 20d. Location - City or Town, State
BALTO., MD. | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
HENRY W. JENKINS & SONS CO.
4905 YORK RD. BALTO., MD. 21212. | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. SEPSIS
Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death
10 DAYS</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. POKUPANEA
Due to (or as a consequence of):</td> <td>10 DAYS</td> </tr> <tr> <td>c. Dehydration
Due to (or as a consequence of):</td> <td>10 DAYS</td> </tr> <tr> <td>d. A.S.C.U.D
Due to (or as a consequence of):</td> <td>2 YEARS</td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. SEPSIS
Due to (or as a consequence of): | Approximate Interval Between Onset and Death
10 DAYS | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. POKUPANEA
Due to (or as a consequence of): | 10 DAYS | c. Dehydration
Due to (or as a consequence of): | 10 DAYS | d. A.S.C.U.D
Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death) | a. SEPSIS
Due to (or as a consequence of): | Approximate Interval Between Onset and Death
10 DAYS | | | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. POKUPANEA
Due to (or as a consequence of): | 10 DAYS | | | | | | | | | | | | | | | | | |
| | c. Dehydration
Due to (or as a consequence of): | 10 DAYS | | | | | | | | | | | | | | | | | |
| | d. A.S.C.U.D
Due to (or as a consequence of): | 2 YEARS | | | | | | | | | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | | 29c. License number
042736 | | 29d. Date signed (Month, Day, Year)
5-26-99 | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
AYMAN AKKAD M.D. 7600 OSLER DR. TOWSON, MD. 21204. | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | 32. Registrar's Signature
 | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17616

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDITH MAE KOCH

2. Date of Death

Month Day Year
MAY 30 1999

3. Time of Death

9:20 AM

4a. Facility Name (If not institution, give street and number)

FRANKLINWOODS NURS. CENTER

4b. City, Town, or Location of Death

ROSEDALE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

219-30-1674

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG 13, 1934

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

PERRY HALL, MD

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11204 LILAC LANE

10f. Zip Code

21128

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10 TH

College (1-4 or 5+)
NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DOG GROOMER

16b. Kind of Business/Industry

PET SHOP

17. Father's Name (First, Middle, Last)

JOHN C FINCK, JR

18. Mother's Name (First, Middle, Maiden Surname)

MARGARET G. EASTWOOD

19a. Informant's Name/Relationship (Type, Print)

HENRY W. KOCH

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11204 LILAC LA. PERRY HALL, MD 21128

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MORELAND MEM.

Date

6/3/99

20c. Location - City or Town, State

BALTO. CO. MD.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

HARTLEY MILLER FUNERAL HOME, CHTD.
7527 HARFORD RD. BALTO MD 21234

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular accident

Approximate Interval Between Onset and Death

3 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D45904

29d. Date signed (Month, Day, Year)

5-31-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KRISTINE C. SALVO MD 9524 Belair Rd Baltimore MD 21236

31. Date filed (Month, Day, Year)

JUN - 1 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 17617

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|---------------------------|---|---|---|--|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ANDREW J. LEWIS | | | | | | 2. Date of Death
Month Day Year
JUNE 01 1999 | | 3. Time of Death
06:52 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
ST. AGNES HOSPITAL | | | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
238-16-3147 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
87 Yrs. | | 8. Date of Birth (Month, Day, Year)
02/08/1912 | | 9. Birthplace (State or Foreign Country)
N. Carolina | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
527 Loudon Avenue | | | | 10f. Zip Code
21229 | | 10g. Citizen of What Country?
U.S.A. | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th
College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | | 16b. Kind of Business/Industry | | | |
| 17. Father's Name (First, Middle, Last)
James Lewis | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Hattie Bell Perry | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Odessa Goodman | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
527 Loudon Avenue, Baltimore, MD 21229 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery | | | Data | | 20c. Location - City or Town, State
Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee
Willie E. Howell | | | 22. Name and Address of Facility
Willie E. Howell, Jr.
LEROY O. DYETT & SON FUNERAL HOME, P.A.
4600 LIBERTY HEIGHTS AVENUE, BALTO. MD | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. UROSEPSIS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death
48 HOURS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28t. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
Dr. M. M. M. MEDICAL RESIDENT | | | | 29c. License number
P12593 | | | 29d. Date signed (Month, Day, Year)
JUNE 1, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MOHAMMAD Y. KHAN, M.D. 900 CATON AVENUE, BALTIMORE, MARYLAND 21229 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | | 32. Registrar's Signature
James B. Spauls | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

JOSEPH A. LOYAL

AMEND ITEM# 8 PER FH G772, 672, 99 EW
F PER MEO G775 9-9-89 WD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17618

| | | | | | | | | | | |
|--|---|--|--|---|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Joseph A. Loyal | | | | 2. Date of Death
Month Day Year
MAY 29, 1999 | | | | 3. Time of Death
0830 AM | |
| | 4a. Facility Name (If not institution, give street and number)
2300 EAST BIDDLE STREET | | | | 4b. City, Town, or Location of Death
BALTIMORE | | | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
212-20-9120 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
39 Yrs. | | 8. Date of Birth (Month, Day, Year)
5-24-60 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | 10a. State
Md. | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number
812 Webb Ct. | | | | 10f. Zip Code
21202 | |
| | 10g. Citizen of What Country?
USA | | | | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9th College (1-4 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
UNK. | | | | 16b. Kind of Business/Industry
UNK. | | | | 17. Father's Name (First, Middle, Last)
Joseph Loyal Sr. | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Marie Harris | | | | 19a. Informant's Name/Relationship (Type, Print)
Janice Lawson - Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
812 Webb Ct. Balto. Md. 21202 | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Voshell Cemetery | | | | 20c. Location - City or Town, State
6-4-99 Balto. Md. | |
| | 21. Signature of Funeral Service Licensee
[Signature] | | | | 22. Name and Address of Facility
Jeff Miller P.C. Funeral Home & Services
1639 N. Broadway Balto. Md. 21213 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

SEIZURE DISORDER | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year)
5-29-99 | | | | 28b. Time of Injury
8:15 | | | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred
UNKNOWN | | | | 28e. Place or injury - At home, farm, street, factory, office building, etc. (Specify)
UNKNOWN | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
UNKNOWN | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
[Signature] | | | | 29c. License number
O.C.M.E. | | |
| 29d. Data signed (Month, Day, Year)
MAY 29, 1999 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mary Paton Koron | | | | 31. Data filed (Month, Day, Year)
JUN - 2 1999 | | |
| 32. Registrar's Signature
[Signature] | | | | 33. Registrar's Name
B. Sparks | | | | 34. Registrar's Title
Registrar | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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LIBRARY

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State of Maryland / Department of Health and Mental Hygiene

ITEM: #23 PART I, PER MD G772 7-2-99 WR.

Certificate of Death

Reg. No.

99 17619

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph G

Leichling

2. Date of Death

Month

Day

Year

MAY 21, 1999

3. Time of Death

7:52 AM

4a. Facility Name (If not institution, give street and number)

Baltimore Rehabilitation + Extended Care

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

218-03-0948

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

Feb. 3, 1921

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1232 East Fort Avenue

10f. Zip Code

21230

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
 If Yes, Give Year or Dates: 42-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

 Elementary/Secondary (0-12) 9
 College (1-4 or 5+) 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Longshoreman

16b. Kind of Business/Industry

Shipping

17. Father's Name (First, Middle, Last)

George Leichling

18. Mother's Name (First, Middle, Maiden Surname)

Julia Himes

19a. Informant's Name/Relationship (Type, Print)

Agnes V. Leichling / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1232 E. Fort Avenue, Baltimore Maryland 21230

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crownsville Veterans Cemetery

Date

May 24, 1999

20c. Location - City or Town, State

Crownsville Maryland

21. Signature of Funeral Service Licensee Victor P. Doda, Jr.

22. Name and Address of Facility

Charles L. Stevens Funeral Home, Inc.

1501 East Fort Avenue, Baltimore Maryland 21230

23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.

Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

 STROKE
 a. ~~Respiratory failure~~

Due to (or as a consequence of):

b. Probable aspiration

Due to (or as a consequence of):

c. Vomiting

Due to (or as a consequence of):

d. Immobility

1 hour

1 hour

4 years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

 Multiinfant Dementia, Bilateral above
 knee amputations, Stroke, Recurrent
 Urinary tract infections

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D0032548

29d. Date signed (Month, Day, Year)

May 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

 PERRY L COLVIN MD
 10 N Greene St. Baltimore

31. Date filed (Month, Day, Year)

JUN - 2 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


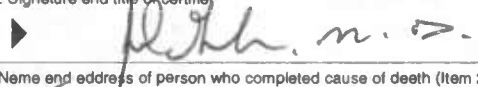
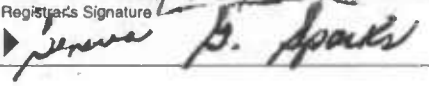
State of Maryland / Department of Health and Mental Hygiene

99 17620

Amended Item#7 per FH G772 6/2/99 EW

Certificate of Death

Reg. No.

| | | | | | |
|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Reta Lorck | | 2. Date of Death
Month 5 Day 30 Year 99 | | 3. Time of Death
11:05 AM |
| | 4a. Facility Name (If not institution, give street and number)
Sinai Hospital | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
217-05-3171 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
86 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
7/6/12 | | 9. Birthplace (State or Foreign Country)
GERMANY | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALTIMORE | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number
1 POMONA EAST #204 | | | 10f. Zip Code
21208 | | 10g. Citizen of What Country?
U.S.A. |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary <input type="checkbox"/> Secondary (0-12) <input checked="" type="checkbox"/> College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SALES | | 16b. Kind of Business/Industry
RETAIL | |
| 17. Father's Name (First, Middle, Last)
ISIDORE MAIER | | | 18. Mother's Name (First, Middle, Maiden Surname)
FLORENCE WOLF | | |
| 19a. Informant's Name/Relationship (Type, Print)
FLORENCE GOLDNER / DAUGHTER | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3411 FIELDING ROAD - BALTIMORE, MD 21208 | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHEVRA AHAVAS CHESED | | 20c. Location - City or Town, State
5/31/99 RANDALLSTOWN, MD | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death)
e. Aspiration pneumonia
Due to (or as a consequence of):
f. Lysis of adhesions
Due to (or as a consequence of):
g. Partial small bowel obstruction
Due to (or as a consequence of):
h. | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23c. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
13383 | | 29d. Date signed (Month, Day, Year)
5/30/99 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Joel Gerber, M.D. Sinai Hospital / The Johns Hopkins Hospital | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | 32. Registrar's Signature
 | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

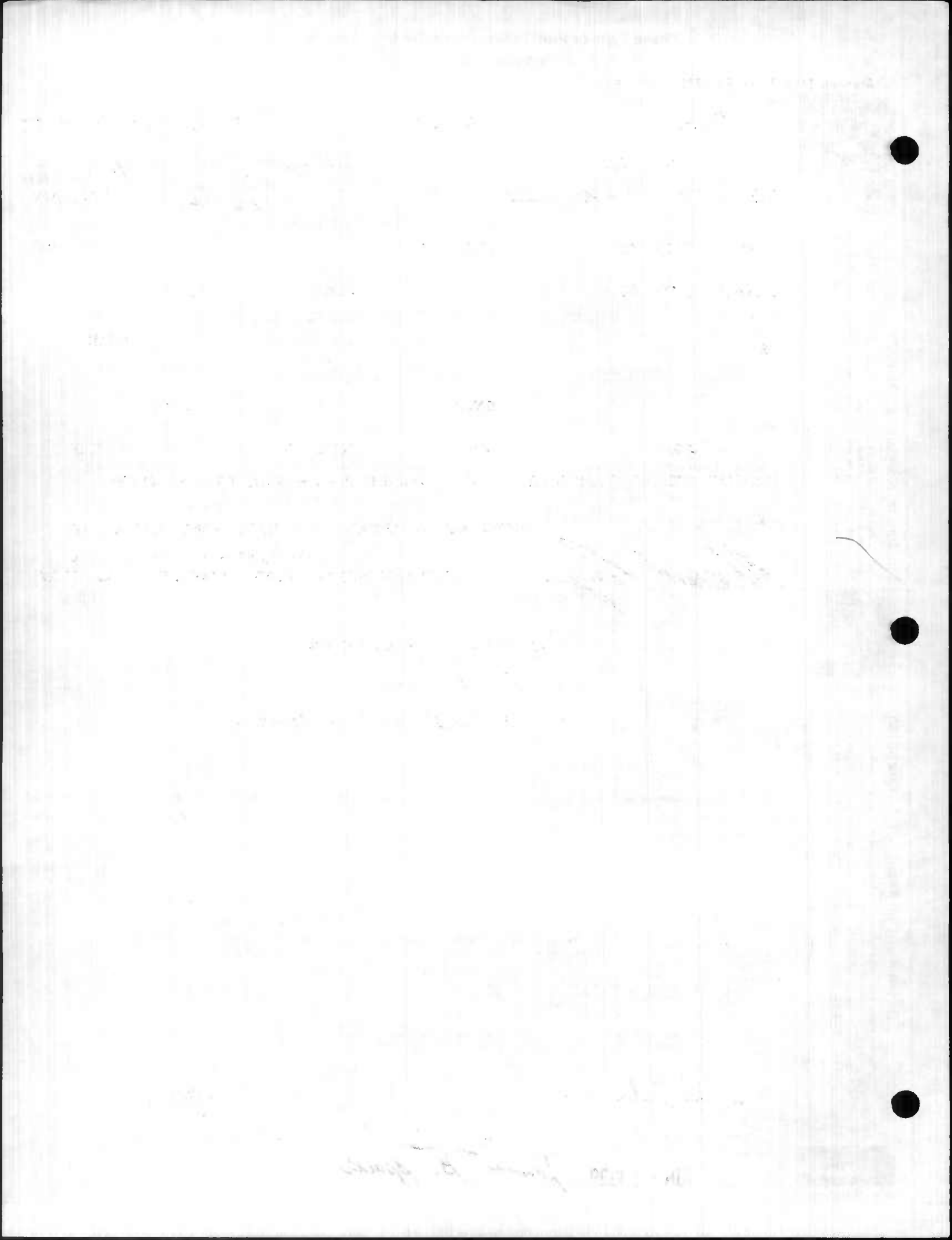
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified immediately.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17621

| | | | | | | | | |
|--|--|---|--|---|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ROSE LAZARUS | | | | 2. Date of Death
Month MAY Day 29 Year 1999 | | 3. Time of Death
1:10PM | |
| | 4a. Facility Name (If not institution, give street and number)
PIKESVILLE NURSING HOME | | | | 4b. City, Town, or Location of Death
PIKESVILLE | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
216-36-8786 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
93 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
Month FEB Day 14 Year 1906 | | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
6711 PARK HTS. AVE. APT. 412 | | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
NURSE | | | 16b. Kind of Business/Industry
MEDICINE | |
| 17. Father's Name (First, Middle, Last)
LOUIS SAGER | | | | 18. Mother's Name (First, Middle, Maiden Surname)
FANNIE SHINDLER | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
ALICE HABER /DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11716 MAGRUDER LANE ROCKVILLE, MD. 20852 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
BETH TFILOH CONGREGATION | | Date
5/30/99 | | 20c. Location - City or Town, State
WOODLAWN, MD |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS. INC.
8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerosis
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
10 years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D0020964 | | 29d. Date signed (Month, Day, Year)
5/29/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jerome H. Ainsberg, M.D. 2630 Liberty Plaza Mall Randallstown, MD 21133 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760, 6

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17622

Amended Item#7,18 perFH G772 6/2/99 EW

| | | | | | | | | | |
|--|---|---|--|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOSEPH P LUONGO SR | | | | 2. Date of Death
Month MAY Day 31 Year 1999 | | 3. Time of Death
505 P | | |
| | 4a. Facility Name (If not institution, give street and number)
HOWARD COUNTY GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death
COLUMBIA | | 4c. County of Death
HOWARD | | |
| Funeral
Director | 5. Social Security Number
049-03-0291 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
83 Yrs. | | 8. Date of Birth (Month, Day, Year)
05/03/1916 | | |
| | 9. Birthplace (State or Foreign Country)
CT | | 10a. State
Md | | 10b. County
Baltimore | | 10c. City, Town or Location
Catonsville | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
4 F Winesap Court | | 10f. Zip Code
21228 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Army Intelligence | | 16b. Kind of Business/Industry
Dept of the Army | | 17. Father's Name (First, Middle, Last)
Fleice Luongo | | 18. Mother's Name (First, Middle, Maiden Surname)
Unknown Raffaella A Zambrano | |
| 19a. Informant's Name/Relationship (Type, Print)
Joseph Luongo, Jr/ Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6131 Forest Lane, Eldersburg, Md. 21784 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest Vet Cem | | 20c. Location - City or Town, State
6/3/99 Owings Mills, Md | |
| 21. Signature of Funeral Service Licensee
M. K. Marshall | | 22. Name and Address of Facility
Sterling Ashton Schwab Funeral Home, Inc
736 Edmondson Avenue, Balto, Md. 21228 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ASPIRATION PNEUMONIA
Due to (or as a consequence of):
b. CHRONIC BRONCHITIS
Due to (or as a consequence of):
c. LEGIONELLA PNEUMONIA
Due to (or as a consequence of):
d. | | Approximate Interval Between Onset and Death
2 WEEKS
YEARS
2 WEEKS | | | |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ALCOHOL ABUSE
MYCOBACTERIUM INFECTION | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and Title of Certifier
[Signature] | | 29c. License number
D39629 | | 29d. Date signed (Month, Day, Year)
JUNE 1 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ALEXANDER SY MD 10724 LITTLE PATUXENT PARKWAY SUITE 200, COLUMBIA MD 21044 | | 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | 32. Registrar's Signature
[Signature] | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMENDED ITEM #3 PER MD G774 8/17/99 AH

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17623

Amend Item #11, per FH, G774, 8/2/99, gap

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN MACON, SR

2. Date of Death

MAY

30, 1999

3. Time of Death

10:35pm

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTO.

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

161-14-8690

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

02-06-21

9. Birthplace (State or Foreign Country)

BOLOGIS, MISS

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

819 CHAUNCEY AVE

10f. Zip Code

21217

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SELF EMPLOYED

16b. Kind of Business/Industry

WELDER

17. Father's Name (First, Middle, Last)

WILLIAM MACON

18. Mother's Name (First, Middle, Maiden Surname)

MAMIE MACON

19a. Informant's Name/Relationship (Type, Print)

JOHN MACON (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

819 CHAUNCEY AVE, BALTO. MD 21217

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY

Date

6-3-99

20c. Location - City or Town, State

BALTO, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LEROY O DYETT & SON FUNERAL HOME

4600 LIBERTY HGHTS AVE. BALTO. MD 21207

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

Stroke

Approximate Interval Between Onset and Death

minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

recent prior stroke, Normal pressure

hydrocephalus, Dementia, Chronic leukemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Medical Attending

29c. License number

D17118

29d. Date signed (Month, Day, Year)

6/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Schwartz M.D. 115 E. Monroe Ave 21212

31. Date filed (Month, Day, Year)

JUN - 2 1999

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. The first part of the document discusses the importance of maintaining accurate records of all transactions.

CARL MORRIS

ITEMS: #23 PART 1, 27, 28A-F PER MEO G772 9-10-99 WR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17624

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CARL MORRIS

2. Date of Death

Month

Day

Year

MAY

29

1999

3. Time of Death

0405 AM

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL E.R.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A.

Funeral
Director

5. Social Security Number

Unknown.

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

45

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month

Day

Year

Feb.

11

1954

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A.

10c. City, Town or Location

BALTO.

MD.

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3952 Wilsby Ave

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

N/A.

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MAINTENANCE WORK

16b. Kind of Business/Industry

N/A.

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

MARY JACKSON

19a. Informant's Name/Relationship (Type, Print)

CLARA Nunn

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3952 Wilsby Ave BALTO. MD 21218

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Vossell cem

Date

6-4-99

20c. Location - City or Town, State

BALTO. MD.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

BETTS FUNERAL HOME
1129 N. CAROLINE ST BALTO. MD. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. NARCOTIC, COCAINE AND ALCOHOL INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☒ Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation
☐ Accident ☒ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

Found: 5-29-99

28b. Time of Injury

Found: A M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

FOUND: RESIDENCE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2305 E. OLIVER STREET, BALTIMORE, MARYLAND

29a. Certifier (Check only one)

☐ Certifying Physician☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

MAY 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KARYSMA KOGUE 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUN - 2 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17625

| | | | | | | | | | | |
|--|--|------------------------------------|---|---|--|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Helen V. Mauler | | | | | 2. Date of Death
Month May Day 30 Year 1999 | | 3. Time of Death
4:15 A.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
8108 Highpoint Road | | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Anne Arundel | | |
| Funeral
Director | 5. Social Security Number
213 28 3921 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
66 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb. 7, 1933 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
8108 Highpoint Road | | | | | 10f. Zip Code
21226 | | 10g. Citizen of What Country?
U.S. | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th College (1-4 or 5+) | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Own Home | | |
| 17. Father's Name (First, Middle, Last)
Robert Reightler | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Helen M. Adams | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
George Mauler / son | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8531 Creek Road Pasadena, Maryland 21122 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Memorial Park | | Date
6/1/99 | | 20c. Location - City or Town, State
Glen Burnie, Maryland | | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | | 22. Name and Address of Facility
Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 21225 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Hepatic failure
Due to (or as a consequence of):
b. Hepatic metastatic disease
Due to (or as a consequence of):
c. probable G.I. upper malignancy
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death
1 month
6 months | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.
Hypertension | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier
<i>[Signature]</i> | | | 29c. License number
D30568 | | 29d. Date signed (Month, Day, Year)
5-1-99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. SHOBHA D. REDDY 7845 BAKWOOD RD Ste 204 Glen Burnie Md. 21061 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 02 1999 | | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17626

| | | | | | | | | |
|--|--|--|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ELEANOR MARY MIODUSZEWSKI | | | | 2. Date of Death
Month Day Year
May 28, 1999 | | 3. Time of Death
9:20 AM | |
| | 4a. Facility Name (If not institution, give street and number)
HOWARDS HOUSE ASSISTED LIVING | | | | 4b. City, Town, or Location of Death
TANEYTOWN | | 4c. County of Death
CARROLL | |
| Funeral
Director | 5. Social Security Number
212-05-9249 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | 8. Date of Birth (Month, Day, Year)
Jul 31, 1919 | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country)
MD | | 10. State
MD | | 10b. County
CARROLL | |
| To Be Completed by Funeral Director | 10a. City, Town or Location
TANEYTOWN | | 10c. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10d. Street and Number
4949 Middleburg Road | | 10e. Zip Code
21787 | |
| | 10f. Citizen of What Country?
USA | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
COOK | | 16b. Kind of Business/Industry
RESTAURANT | |
| | 17. Father's Name (First, Middle, Last)
FELIX STACHOROWSKI | | 18. Mother's Name (First, Middle, Maiden Surname)
SOPHIA JARWINSKI | | 19a. Informant's Name/Relationship (Type, Print)
JOSEPH MIODSZEWSKI | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
212 ELKS ROAD, BALTIMORE, MD 21221 | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ST. STANISLAUS CEMETERY | | 20c. Date
Jun 11 1999 | | 20d. Location - City or Town, State
BALTIMORE, MD | |
| | 21. Signature of Funeral Service Licensee
<i>Charles Kaczorowski</i> | | 22. Name and Address of Facility
KACZOROWSKI FUNERAL HOME
1201 DUNDALK AVENUE, BALTIMORE, MD 21222 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Cerebral Vascular Accident
Due to (or as a consequence of):
Chronic Heart Failure
Due to (or as a consequence of):
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
ANEMIA
Hypertension
Hypothyroidism | | 23b. Approximate Interval Between Onset and Death
10 min
5 yrs. | |
| | 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ANEMIA
Hypertension
Hypothyroidism | | 23d. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
May 28 1999 | |
| | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>John Sylling</i> | | 29c. License number
D20 330 | | 29d. Date signed (Month, Day, Year)
5/28/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John Sylling 104 N. Main St. Union Bridge, Md | | 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | 32. Registrar's Signature
<i>James B. Sparks</i> | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17627

| | | | | | | | | | | | | | | | | | | | | | | |
|---|---|-----------------------------|---|---|--|---------------------|--|--|---|---|----|-----------------------|--------|----|------------------------|---------|----|-----------------------------|---------|----|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
NELLIE H. MITCHELL | | | | 2. Date of Death
Month Day Year
MAY 28 1999 | | | | 3. Time of Death
0450 | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
UNION MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | | | 4c. County of Death
N/A | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
219-26-4380 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
69 Yrs. | | 8. Date of Birth (Month, Day, Year)
2-14-30 | | 9. Birthplace (State or Foreign Country)
MD. | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | 10a. State
MD. | | | | 10b. County
N/A | | | | | | | | | | | | | |
| 10c. City, Town or Location
BALTIMORE | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | |
| 10e. Street and Number
5612 READY AVE. | | | | 10f. Zip Code
21212 | | | | 10g. Citizen of What Country?
USA | | | | | | | | | | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) -10- College (1-4 or 5+) -0- | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
DOMESTIC | | | | 16b. Kind of Business/Industry | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
HARVEY MOSES | | | | 18. Mother's Name (First, Middle, Maiden Surname)
NELLIE BROWN | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
ALFRED MITCHELL (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5523 LOTHIAN RD. BALTIMORE, MARYLAND 21212 | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
METRO. CREMATORY | | 20c. Date
6-2-99 | | 20d. Location - City or Town, State
BALTIMORE, MARYLAND | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
Dorothy Hector CFSP | | | | 22. Name and Address of Facility
PHILLIPS FUNERAL HOME, P.A.
1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Myocardial Infarction</td> <td>30 min</td> </tr> <tr> <td>b.</td> <td>Dilated cardiomyopathy</td> <td>5 years</td> </tr> <tr> <td>c.</td> <td>Peripheral vascular disease</td> <td>5 years</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Myocardial Infarction | 30 min | b. | Dilated cardiomyopathy | 5 years | c. | Peripheral vascular disease | 5 years | d. | | |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Myocardial Infarction | 30 min | | | | | | | | | | | | | | | | | | | |
| | b. | Dilated cardiomyopathy | 5 years | | | | | | | | | | | | | | | | | | | |
| | c. | Peripheral vascular disease | 5 years | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Pulmonary hypertension
Chronic obstructive pulmonary disease
Gangrenous bilateral lower extremities | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | | | | | | | | | | | | | | | | | | | |
| 28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
Joseph A Besso MD Surgical Intern
29c. License number
AT2438946.N33
29d. Date signed (Month, Day, Year)
MAY 28 1999 | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Union Memorial Hospital University of Baltimore Baltimore MD Joseph A Besso JK | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999
32. Registrar's Signature
[Signature] | | | | | | | | | | | | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17628

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alex Martinez

2. Date of Death

May 26, 1999

3. Time of Death

1025

4a. Facility Name (If not institution, give street and number)

Howard Co. Gen Hosp.

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

N/A

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 26, 1999

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

9342 GENTLE FOLK

10f. Zip Code

21045

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☒ Yes 2 ☐ No Specify: Puerto Rican14. Race - American Indian,
Black, White, etc.

Specify: HISPANIC

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

ALEXI MARTINEZ

18. Mother's Name (First, Middle, Maiden Surname)

LETA BAUMANN

19a. Informant's Name/Relationship (Type, Print)

LETA BAUMANN / MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9342 GENTLE FOLK, Columbia, MD 21045

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

HOLY ROSARY CEMETERY 5/28/99

Date

20c. Location - City or Town, State

DUNDALK, MD.

21. Signature of Funeral Service Licensee

Charles Kaczmarek

22. Name and Address of Facility

KACZOROWSKI Funeral Home PA.
1201 DUNDALK AVE. BUNTO. MD 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. pulmonary hypertension

Due to (or as a consequence of)

Approximate
Interval Between
Onset and Death

immediate

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. multistage kidneys

Due to (or as a consequence of)

immediate

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Margot Watson, MD

29c. License number

D41598

29d. Date signed (Month, Day, Year)

5.26.99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Margot Watson 11085 Little Patuxent Pky. Columbia, Md

State
Registrar

31. Date (Month, Day, Year)

JUN 2 1999

32. Registrar's Signature

Benita B. Sparks

Baltimore, Maryland 21215-0020

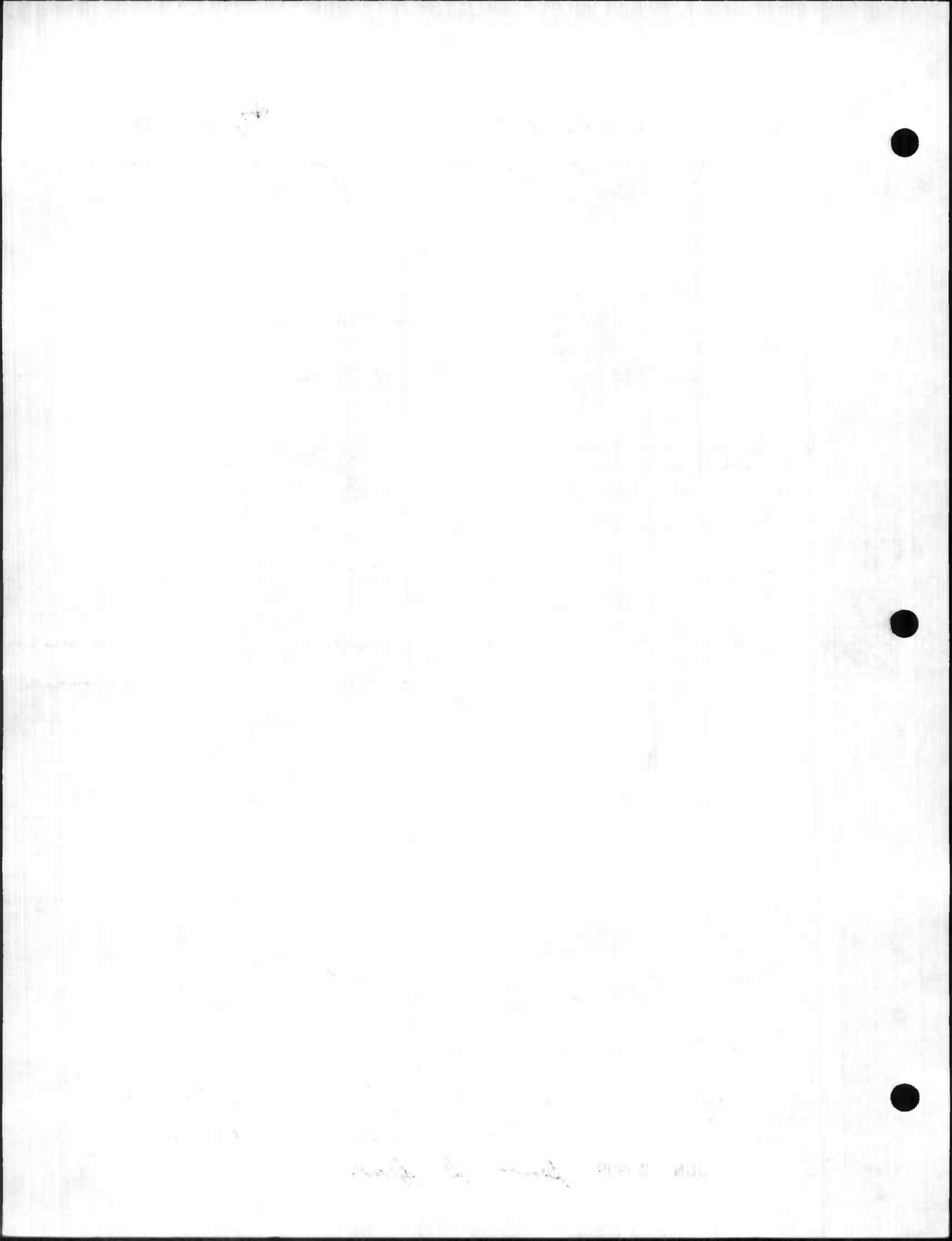
permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
2024.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17629

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Elaine Lee Nelson

2. Date of Death

May 29, 1999

3. Time of Death

2205

4a. Facility Name (If not institution, give street and number)

Union Hospital

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil Co.

5. Social Security Number

219-28-8189

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 18, 1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil Co.

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8 Tern Court

10f. Zip Code

21921

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12 yrs.

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Oscar P. McCauley

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ellen Devlin

19a. Informant's Name/Relationship (Type, Print)

Mr. Royce W. Nelson (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 Tern Court Elkton, Maryland 21921

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lake View Mem. Park

Date

6/3/99

20c. Location - City or Town, State

Sykesville, Maryland

21. Signature of Funeral Service Licensee Michael E. Canapp

Michael E. Canapp

22. Name and Address of Facility

5305 Harford Road
LEONARD J. RUCK, INC. Baltimore, MD 2121423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Pancreatic Carcinoma - Metastatic

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 months

Sequitally list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

H. Farkas, MD

29c. License number

D15314

29d. Date signed (Month, Day, Year)

May 30, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

H Farkas, MD VNA / Northern Chesapeake Hospice, Elkton, MD

31. Date filed (Month, Day, Year)

JUN - 2 1999

32. Registrar's Signature

B. Spahr

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

KATHRYN MARY O'DONNELL
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, 27, 28A-F PER MEO G772 6-9-99 WR.

Certificate of Death

Reg. No.

99 17630

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
KATHRYN MARY O'DONNELL | | | | 2. Date of Death
Month: MAY Day: 26 Year: 1999 | | 3. Time of Death
2245 |
| | 4a. Facility Name (If not institution, give street and number)
1706 VALLEY BROOK DRIVE | | | | 4b. City, Town, or Location of Death
KINGSVILLE | | 4c. County of Death
HARFORD |
| Funeral
Director | 5. Social Security Number
214 88 7912 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
22 Yrs. | If Under 1 Year
Months: Days: Hours: Min. | 8. Date of Birth (Month, Day, Year)
March 4, 1977 | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | |
| 10a. State
Maryland | | 10b. County
Harford | | 10c. City, Town or Location
Kingsville | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
1706 Valleybrook Dr. | | | | 10f. Zip Code
21087 | | 10g. Citizen of What Country?
United States | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 College (1-4 or 5+): 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Student | | 16b. Kind of Business/Industry
College | |
| 17. Father's Name (First, Middle, Last)
Joseph Patrick O'Donnell | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Alberta N. Nelson | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Alberta N. O'Donnell / Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1706 Valleybrook Dr., Kingsville, MD 21087 | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Green Mount Crematory 5/31/99 | | Data | | 20c. Location - City or Town, State
Baltimore, MD | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
CAFA Stephen D. Lohrmann P.A.
8717 Green Pastures Dr., Baltimore, MD 21286 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. COMBINED DRUG AND ALCOHOL INTOXICATION
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year)
5-26-99 | | 28b. Time of Injury
UNKNOWN M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how injury occurred
SUBJECT INGESTED DRUG AND ALCOHOL | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
HOME | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
1706 VALLEYBROOK DR. KINGSVILLE, MD | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
MAY 27, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| State Registrar | | 31. Date filed (Month, Day, Year)
JUN 2 1999 | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AH

ORIGINAL



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17631

| | | | | | | | | |
|--|--|---|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HILARY OWRUTSKY | | | | 2. Date of Death
Month Day Year
MAY 28 1998 | | 3. Time of Death
5:30pm | |
| | 4a. Facility Name (If not institution, give street and number)
SINAI HOSPITAL OF BALTIMORE | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
216-28-0656 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
67 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
SEPT 15, 1931 | 9. Birthplace (State or Foreign Country)
NEW YORK |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
RANDALLSTOWN | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
8606 LUCERNE RD. | | | | 10f. Zip Code
21133 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | | 16b. Kind of Business/Industry
OWN HOME | |
| 17. Father's Name (First, Middle, Last)
SOL HOLLANDER | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ETTA YARESH | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
SAMUEL OWRUTSKY (HUS.) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8606 LUCERNE RD. RANDALLSTOWN, MD 21133 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ANSHE EMUNAH-AITZ CHAIM | | 20c. Location - City or Town, State
5/31/99 BALTIMORE, MD | | |
| 21. Signature of Funeral Service Licensee
8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC. | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediata Cause (Final disease or condition resulting in death)
a. SEPSIS
Due to (or as a consequence of):
b. CLOSTRIDIUM DIFFICILE COLITIS
Due to (or as a consequence of):
c. URINARY TRACT INFECTION
Due to (or as a consequence of):
d. LEFT PONS CEREBROVASCULAR ACCIDENT

Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
6 DAYS
2 WEEKS
2 WEEKS
7 DAYS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.
END STAGE RENAL DISEASE
DIABETES MELLITUS TYPE II
LEFT LEG GRAFT WOUND | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
D. S. S. MD | | 29c. License number
P12333 | | 29d. Date signed (Month, Day, Year)
MAY 28 1998 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOSEPHINE OWUSU-SAKYI, 2401 WEST BELVEDERE AVENUE, BALTIMORE MD 21215 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | | | 32. Registrar's Signature
[Signature] | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

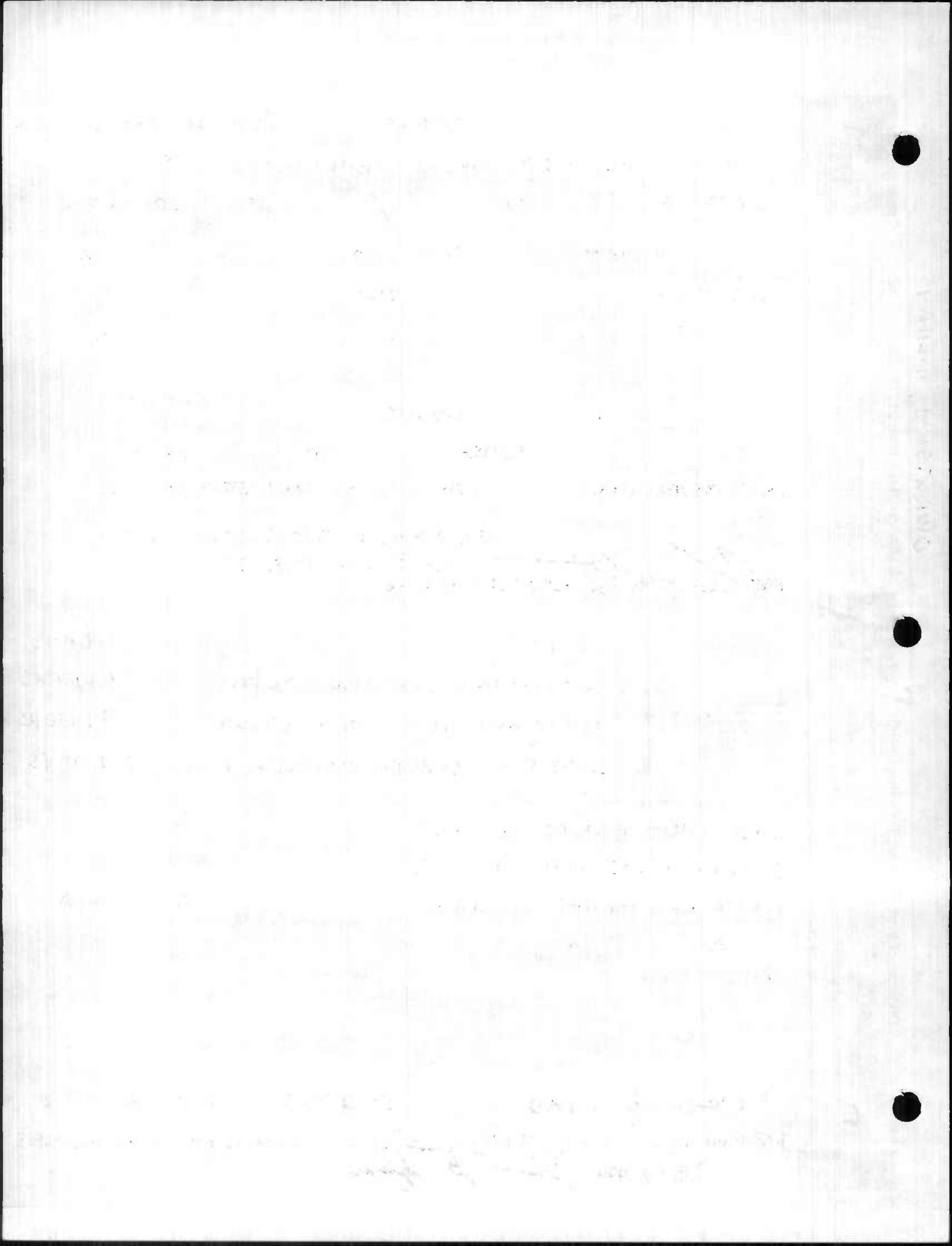
Important: If item 27 is marked other than "natural," or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17632

| | | | | | | | | |
|--|---|--|--------------------------|--|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ROBERT PATTERSON | | | | 2. Date of Death
Month JUN Day 1 Year 1999 | | 3. Time of Death
1225 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Levindale Nursing Home | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
220-24-8891 | | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
73 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
4 6 26 | 9. Birthplace (State or Foreign Country)
South Carolina |
| | Usual Residence of Decedent | | | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
1 Yes 2 No | |
| 10e. State
Md | | 10b. County
N/A | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
1 Yes 2 No | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) UKN | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Labor | | 16b. Kind of Business/Industry
Kalex | | |
| 17. Father's Name (First, Middle, Last)
Wash Patterson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ella Leitner | | | | |
| 19e. Informant's Name/Relationship (Type, Print)
Zula Patterson - wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1508 E. Hoffman St. Balto. Md. 21213 | | | | |
| 20e. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest Cemetery | | 20c. Location - City or Town, State
6-8-99 Owings Mill, Md. | | |
| 21. Signature of Funeral Service Licensee
Jeff Miller | | | | 22. Name and Address of Facility
Jeff Miller R.P. Funeral Home & Services 1639 N. Broadway Balto. Md. 21213 | | | | |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line.

Aspiration Pneumonia
Respiratory Failure
Septicemia | | | | | | Approximate Interval Between Onset and Death
1 day | | |
| 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | | | | | | 24e. Was an autopsy performed?
1 Yes 2 No | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | | | | | | | | |
| 25. Was case referred to medical examiner?
1 Yes 2 No | | | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | |
| 27. Manner of Death
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | | | 28e. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29e. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
Jason M. Lynn | | 29c. License number
D33943 | | 29d. Date signed (Month, Day, Year)
6/1/99 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jason R. Lynn | | | | 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | | | |
| 32. Registrar's Signature
James B. Sparks | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17633

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Oscar Patterson

2. Date of Death

May 29 1999

3. Time of Death

3:50 PM

4a. Facility Name (If not institution, give street and number)

LIBERTY MEDICAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

219 12 8250

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

03/02/1924

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2528 N. ELLAMONT ST.

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

BLACK

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

TRUCK DRIVER

16b. Kind of Business/Industry

PENN BROS.

17. Father's Name (First, Middle, Last)

ELLIOTT PATTERSON

18. Mother's Name (First, Middle, Maiden Surname)

BARBER

CURLEY

19a. Informant's Name/Relationship (Type, Print)

VALENCIA BERNER/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2528 N. ELLAMONT ST. BALTO., MD 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

GARRISON FOREST VET. CEM 6/04/99 OWINGS MILLS, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

James A. Morton

22. Name and Address of Facility

JAMES A. MORTON & SONS F.H. INC.

1701 LAURENS STREET BALTO., MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Pneumonia

Due to (or as a consequence of):

b.

Sepsis

Due to (or as a consequence of):

c.

Gangrene

Due to (or as a consequence of):

d.

Renal Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George E. Wickes M.D.

29c. License number

D41365

29d. Date signed (Month, Day, Year)

May 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George E. Wickes M.D. 2600 Liberty Heights Ave. 21215

31. Date filed (Month, Day, Year)

JUN 02 1999

32. Registrar's Signature

George A. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMENDED ITEM #26 PER M.D. G772 6/2/99 AH

Reg. No.

99 17634

Physician
/ Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nelson Franklin Rutledge

2. Date of Death

Month Day Year
May 9, 1999

3. Time of Death

1:45 PM

4a. Facility Name (if not institution, give street and number)

2818 Bradenbaugh Road

4b. City, Town, or Location of Death

White Hall

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

218-14-8940

8. Sex

M 2 ☐ F

7. Age (in yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 9, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

White Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2818 Bradenbaugh Road,

10f. Zip Code

21161

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Dairy Farmer

16b. Kind of Business/Industry

Farming

17. Father's Name (First, Middle, Last)

Jacob Franklin Rutledge

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Orsburn

19a. Informant's Name/Relationship (Type, Print)

Olive B. Rutledge

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2818 Bradenbaugh Road, White Hall, MD 21161

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Bethel Presbyterian

Cemetery

Date

5/13/99

20c. Location - City or Town, State

White Hall,

Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

J.J. Hartenstein Mortuary

19 S. Main St., Stewartstown, PA 17363

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

CARDIOMYOPATHY

2 YEARS

Due to (or as a consequence of):

VALVULAR HEART DISEASE

10 YEARS

Due to (or as a consequence of):

ISCHEMIC HEART DISEASE

10 YEARS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of injury

(Month, Day, Year)

28b. Time of

injury

28c. Injury at

work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dean L. Vassar, MD

29c. License number

D16036

29d. Date signed (Month, Day, Year)

MAY 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEAN L VASSAR 104 PLUMTREE RD #110, BEL AIR, MD 21015

31. Date filed (Month, Day, Year)

JUN 2 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/ Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17635

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOYCE R. ROGERS

2. Date of Death

MAY 30 1999

3. Time of Death

0435 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MARYLAND GENERAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

CITY

5. Social Security Number

213-64-5694

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

44 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10-26-54

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1717 MADISON AVE.

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
-12-

College (1-4 or 5+)

-0-

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

DISABLED

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

WILLIAM ROGERS

18. Mother's Name (First, Middle, Maiden Surname)

GERTRUDE PERVIS

19a. Informant's Name/Relationship (Type, Print)

SHAWNIA ROGERS (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1531 ALGYLE AVE. BALTIMORE, MARYLAND 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MT. ZION CEMETERY

Date

6-3-99

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

Doretha Hector CFSP

22. Name and Address of Facility

PHILLIPS FUNERAL HOME, P.A.
1721-27 N. MONROE ST. BALTIMORE, MARYLAND 2121723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

SEPSIS

Approximate
interval Between
Onset and Death

UNKNOWN

e. Due to (or as a consequence of):

RENAL FAILURE

UNKNOWN

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day Year)

28b. Time of
injury

M

28c. Injury at
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Steven J. Schwartz

29c. License number

D0053850

29d. Date signed (Month, Day, Year)

MAY 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVEN J. SCHWARTZ 40 MARYLAND GENERAL HOSPITAL

31. Date filed (Month, Day, Year)

JUN - 2 1999

32. Registrar's Signature

Jennifer B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
document.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | |
|---|---|---|---|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HOWARD RAY REEDER | | | | 2. Date of Death
Month Day Year
MAY 30, 1999 | | 3. Time of Death
1012 AM | |
| | 4a. Facility Name (If not institution, give street and number)
MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death
CUMBERLAND | | 4c. County of Death
ALLEGANY | |
| Funeral
Director | 5. Social Security Number
245-84-4211 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
48 Yrs. | 8. Date of Birth (Month, Day, Year)
1-28-51 | | 9. Birthplace (State or Foreign Country)
N.C. | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
N.C. | | 10b. County
COLUMBUS | | 10c. City, Town or Location
LAKE WOCAMAW | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
2B E. OAK ST. | | | | 10f. Zip Code
28450 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) -12- College (1-4 or 5+) -2- | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SERVICE AGENT | | 16b. Kind of Business/Industry
AIRLINES | | |
| 17. Father's Name (First, Middle, Last)
SYLVESTER L. REEDER, II | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
BERTHA RAY | | | |
| 19a. Informant's Name/Relationship (Type, Print)
SYLVESTER L. REEDER, III (BROTHER) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
23 ROCK CREST DR. SIGNAL MTN., TN. 37377 | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
VIOLET HILL CEMETERY 6/5/99
MAPLE SPRINGS CREMATORY 6-2-99 | | 20c. Location - City or Town, State
ASHEVILLE, N.C. | | |
| 21. Signature of Funeral Service Licensee
Deeth Hector CF8P | | | | 22. Name and Address of Facility
PHILLIPS FUNERAL HOME, P.A.
1721-27 N. MONROE ST. BALTIMORE, MD 21217 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. HYPERTENSIVE & ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Joseph Pestano, M.D. | | | | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
MAY 31, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestano, 11 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | | | 32. Registrar's Signature
Benjamin B. Sparks | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 17637

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GLADYS L. RUMPLE | | | | 2. Date of Death
Month MAY Day 30 Year 1999 | | 3. Time of Death
230 PM | |
| | 4a. Facility Name (If not institution, give street and number)
North Arundel Hospital | | | | 4b. City, Town, or Location of Death
Glen Burnie | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
217-16-8046 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
76 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sept. 19, 1922 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Odenton | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
329 Locust Road | | | | 10f. Zip Code
21113 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | |
| | 17. Father's Name (First, Middle, Last)
Unknown Johnson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Unknown Jones | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Lou Bruns (Sister-in-law) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6524 32nd Street, Falls Church, VA 22046 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Cemetery | | Date
06/02 | | 20c. Location - City or Town, State
Glen Burnie, MD | |
| | 21. Signature of Funeral Service Licensee
<i>Batist J. Am...</i> | | | | 22. Name and Address of Facility
Hardesty Funeral Home, P.A.
12 Ridgely Avenue, Annapolis, MD 21401 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
b. RENAL FAILURE
Due to (or as a consequence of):
c. DIABETES MELLITUS
Due to (or as a consequence of):
d. HYPERTENSION | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE
ANEMIA
CORONARY ARTERY DISEASE | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>B. M. Allie...</i> | | 29c. License number
H54409 | | 29d. Date signed (Month, Day, Year)
MAY 30, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BENJAMIN MALKIEL, DO NORTH ARUNDEL HOSPITAL GLEN BURNIE, MD | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 02 1999 | | 32. Registrar's Signature
<i>B. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

99-3067-510

99-118

KEVIN, SELLERS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17638

| | | | | | | | | | | | | | | | |
|--|---|--|---|---|--|--|---|---|-------------------------------------|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
KEVIN DWAYNE SELLERS | | | | | | 2. Date of Death
Month MAY Day 27 , Year 1999 | | 3. Time of Death
9:51P.M. | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
SINAI HOSPITAL | | | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
2/12 | | | | | | |
| Funeral
Director | 5. Social Security Number
219-90-1962 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
25 Yrs. | If Under 1 Year
Months | If Under 24 Hrs.
Hours | 8. Date of Birth (Month, Day, Year)
JAN. 7, 1974 | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
2/12 | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 10e. Street and Number
4008 CEDARDALE ROAD | | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
USA | | | | | | | | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: black | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11th grade College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
PIZZA MAKER (baker) | | | 16b. Kind of Business/Industry
Pizza City | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
Dwight McGillers | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Rita Sellers | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Rosetta Simon / Grandmother | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1612 C Cantwell Road Baltimore, Md 21244 | | | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify): | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
LODON PARK CEMETERY | | Date
6/3/99 | | 20c. Location - City or Town, State
Baltimore, Maryland | | | | | | | |
| 21. Signature of Funeral Service Licensee
[Signature] | | | | 22. Name and Address of Facility
CHATAM - HAMPSHIRE F&I
5345 RISTICKTOWN ROAD
BALTIMORE, MD 21215 | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Gunshot Wound
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| | | | | | | | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year)
5/27/99 | | 28b. Time of Injury
2:28p M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
shot multiple times with gun | | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
street | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
4700 Liberty Heights Baltimore, Md | | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | 29b. Signature and title of certifier
Dennis J. Chute | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 28, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute | | | | | | | | | | 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 2 1999 | | | | 32. Registered Signature
[Signature] | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17639

| | | | | | | | | |
|--|---|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Francis Melvin Sherman | | | | 2. Date of Death
Month May Day 29 Year 1999 | | 3. Time of Death
9:29 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Manor Care | | | | 4b. City, Town, or Location of Death
White Marsh | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
220-07-0666 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
77 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 1 1921 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Harford | | 10c. City, Town or Location
Belair | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
602 Lancelot Lane | | 10f. Zip Code
21015 | | 10g. Citizen of What Country?
U.S. of America | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Maintainance Engineer | | 16b. Kind of Business/Industry
Hospital | | | | |
| 17. Father's Name (First, Middle, Last)
Stephen Szurmasczwicz | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Helen Jaskulski | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Joan Gigliotti (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
602 Lancelot Lane Belair, Md. 21015 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St' Stanislaus | | Date
June 2 | | 20c. Location - City or Town, State
Baltimore, Md. | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
W. Dabrowski-Chojnacki F.H.'s P.A.
1005 Dundalk Ave. Baltimore, MD. 21224 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Prostate Cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | |
| Approximate Interval Between Onset and Death
1 year. | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
045475 | | 29d. Date signed (Month, Day, Year)
5/3/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mohammad Rahnema M.D. 17 Fontana Lane 105 Baltimore, Maryland 21237 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 02 1999 | | | | 32. Registrar's Signature
 | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17640

ITEMS: #23 PART I, 27, 28A-F PER MEO G772 6-9-99 WR.

| | | | | | | | | | | | |
|--|---|---|---|----------------------------------|--|---|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Fermon Ketrick Solomon | | | | 2. Date of Death
Month Day Year
MAY 26, 1999 | | | | 3. Time of Death
1050 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
800 BLOCK OF NORTH BOND STREET | | | | 4b. City, Town, or Location of Death
BALTIMORE | | | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
216-84-2508 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
27 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | |
| | 8. Date of Birth (Month, Day, Year)
Jun 21, 1971 | | 9. Birthplace (State or Foreign Country)
MD | | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
292 South Spring Court | | | | 10f. Zip Code
21231 | | 10g. Citizen of What Country?
United States | | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify:
Black | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
10 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Carpenter | | 16b. Kind of Business/Industry
Home Improvement | | | | | | |
| | 17. Father's Name (First, Middle, Last)
George Robert Solomon | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Delores Elizabeth Brown | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Ms. Delores Brown (Mother) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
292 South Spring Court, Baltimore, MD 21231 | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mount Zion Cemetery | | Date
Jun 2 1999 | | 20c. Location - City or Town, State
Baltimore, MD | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Calvin L Williams Funeral Service
3707 Colborne Road Baltimore, MD | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. NARCOTIC INTOXICATION
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
FOUND ON 5-26-99 | | 28b. Time of Injury
UNKNOWN M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
UNKNOWN | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
800 BLK. N. BOND ST. BALTIMORE, MD. | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
O.C.M.E. | | | | 29d. Date signed (Month, Day, Year)
MAY 27, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Arlon Becker, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 2 1999 | | 32. Registrar's Signature
 | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene


Certificate of Death

Reg. No.

99 17641

| | | | | | | | | | | |
|---|---|--|---|---|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ANNETTE SILVER | | | | 2. Date of Death
Month Day Year
MAY 28, 1999 | | | | 3. Time of Death
5:00 PM | |
| | 4a. Facility Name (If not institution, give street and number)
NORTHWEST HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
RANDALLSTOWN | | | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
218-14-4978 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
75 Yrs. | | 8. Date of Birth (Month, Day, Year)
DEC. 25, 1923 | | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
OWINGS MILLS | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number
4409 SILVERBROOK LANE, #101 | | | | 10f. Zip Code
21117 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | | 16b. Kind of Business/Industry
OWN HOME | | |
| | 17. Father's Name (First, Middle, Last)
LOUIS MEYERS | | | | 18. Mother's Name (First, Middle, Maiden Surname)
BESSIE TEMIN | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
JEFFREY SILVER (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5 SCOTT NORMAN CT. OWINGS MILLS, MD 21117 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
RADOMER VEREIN | | Date
5/30/99 | | 20c. Location - City or Town, State
ROSEDALE, MD | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS
Due to (or as a consequence of):
b. PNEUMONIA
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC LYMPHOCYTIC LEUKEMIA | | | | | | | | | |
| State Registrar | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 K.S. RAO, M.D. | | | | 29c. License number
043462 | | 29d. Date signed (Month, Day, Year)
MAY 28, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
K.S. RAO, M.D.
NORTHWEST HOSPITAL CENTER RANDALLSTOWN, MD | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | | | 32. Registrar's Signature
 | | | | | | |

ORIGINAL

Handwritten text at the bottom of the page, possibly a signature or date.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)
Bernice Smallwood

2. Date of Death
Month Day Year
May 28, 1999

3. Time of Death
9:00am

4a. Facility Name (If not institution, give street and number)
3207 Mondawmin Avenue

4b. City, Town, or Location of Death
Baltimore

4c. County of Death
n/a

5. Social Security Number
215-12-3828

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)
77 Yrs.

8. Date of Birth (Month, Day, Year)
Nov. 2, 1921

9. Birthplace (State or Foreign Country)
Md.

10a. State
Md.

10b. County
n/a

10c. City, Town or Location
Baltimore

10d. Inside City Limits
☒ Yes 2 ☐ No

10e. Street and Number
3207 Mondawmin Avenue

10f. Zip Code
21216

10g. Citizen of What Country?
USA

11. Marital Status
1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.
Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+)
10th Grade

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Cashier/Clerk

16b. Kind of Business/Industry
Sunlife Insurance Co.

17. Father's Name (First, Middle, Last)
Ransom Sutton

18. Mother's Name (First, Middle, Maiden Surname)
Ella Rogers

19a. Informant's Name/Relationship (Type, Print)
Carolyn R. King

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3803 Wabash Avenue Apt. 1C Baltimore, Md. 21215

20a. Method of Disposition
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)
Crownsville Veterans Cem

20c. Location - City or Town, State
June 2 Crownsville, Md.

21. Signature of Funeral Director
[Signature]

22. Name and Address of Facility
Nutter Funeral Homes, Inc.
2501 Gwynns Falls PKWY Baltimore, Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. NON-SMALL CELL CARCINOMA OF LUNG WITH
Due to (or as a consequence of):
b. HEPATIC METASTASES
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death
8 MONTHS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death
1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury
M

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier
[Signature] Attending Physician

29c. License number
D19607

29d. Date signed (Month, Day, Year)
06-01-99

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)
Nora E. McCall, MD. 3701 GREENSPRING AVE #104, BALTIMORE, MD 21211

31. Date filed (Month, Day, Year)
JUN 02 1999

32. Registrar's Signature
[Signature]

State Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

10-10-10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17643

| | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|--|--|--|---|-----------------------------------|---|----|---------------------------|--|---|----|--|----|--|----|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
VALERIJA SAULYNAS | | | | 2. Date of Death
Month Day Year
May 31 1999 | | 3. Time of Death
2:45 pm | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
1704 Beechwood Avenue | | | | 4b. City, Town, or Location of Death
Catonsville | | 4c. County of Death
Baltimore | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
193-30-4760 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
73 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 15 1926 | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country)
Lithuania | | 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Catonsville | | | | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | |
| 10e. Street and Number
1704 Beechwood Avenue | | | | 10f. Zip Code
21228 | | 10g. Citizen of What Country?
U.S.A. | | | | | | | | | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
clerk | | 16b. Kind of Business/Industry
Balto. Co. Dept. of Zoning & Permits | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
unknown Urbanus | | | | 18. Mother's Name (First, Middle, Maiden Surname)
unknown | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Sidas A. Saulynas, son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1329 Merry Hill Ct., Belair, Md. 21015 | | | | | | | | | | | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore/Washington Crem. | | 20c. Location - City or Town, State
Laurel, Md. | | 20d. Date
6/2/99 | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
Shanda L. Lemmer | | | | 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Ave., Catonsville, Md. 21228 | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Malignant Lymphoma</td> <td rowspan="4"> Due to (or as a consequence of):

 Due to (or as a consequence of):

 Due to (or as a consequence of):

 Due to (or as a consequence of): </td> <td rowspan="4"> Approximate Interval Between Onset and Death

 2 yrs. </td> </tr> <tr><td>b.</td><td></td></tr> <tr><td>c.</td><td></td></tr> <tr><td>d.</td><td></td></tr> </table> | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Malignant Lymphoma | Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | Approximate Interval Between Onset and Death

2 yrs. | b. | | c. | | d. | |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Malignant Lymphoma | Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | Approximate Interval Between Onset and Death

2 yrs. | | | | | | | | | | | | | | | |
| | b. | | | | | | | | | | | | | | | | | | |
| | c. | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | |
| | | | | | | 24e. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | |
| 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
Chic Waterfield | | | | 29c. License number
024356 | | 29d. Date signed (Month, Day, Year)
June 1, 1999 | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wm. C. WATERFIELD St. Agnes Convent Center 900 Caton Ave Balt. Md 21229 | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 02 1999 | | | | 32. Registrar's Signature
B. Sparks | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17644

| | | | | | | | | |
|--|---|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LEONORA SUNDERS | | | | 2. Date of Death
Month 05 Day 30 Year 99 | | 3. Time of Death
8:03 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Laurel Regional Hospital | | | | 4b. City, Town, or Location of Death
Laurel | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
079-24-8430 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)
79 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
OCTOBER 28, 1919 | 9. Birthplace (State or Foreign Country)
Bahamas |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Laurel | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
9001 Cherry Lane | | | | 10f. Zip Code
20707 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6+H College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Home Maker | | | 16b. Kind of Business/Industry
OWN HOME | |
| 17. Father's Name (First, Middle, Last)
AL Fred STRACHAN | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Beatrice DUNCOMB | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Beverly Gaylor - Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4704 67th Ave Hyattsville, Maryland 20784 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
metropolitan crematory | | 20c. Location - City or Town, State
Alexandria, Va. | | |
| 21. Signature of Funeral Service Licensee
Robert B Baker Jr. | | | | 22. Name and Address of Facility
CHINN FUNERAL SERVICE
2605 So. Shirlington Road ARLINGTON, Va. | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death
48 hours | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Alzheimer's Disease
Non-insulin Dependent Diabetes | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
John Margolis MD | | | | 29c. License number
025430 | | 29d. Date signed (Month, Day, Year)
5/31/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John MARGOLIS, MD 13952 Baltimore Ave. Laurel, MD 20707 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | 32. Registrar's Signature
Beverly B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-17645

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Frances Smith

2. Date of Death

May 29, 1999

3. Time of Death

8:15 p.m.

4a. Facility Name (If not institution, give street and number)

363 Conniston Way

4b. City, Town, or Location of Death

Aberdeen

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

216-16-2571

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 20, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1218 Willow Road

10f. Zip Code

21222

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph Olszewski

18. Mother's Name (First, Middle, Maiden Surname)

Mary F. Tripul

19a. Informant's Name/Relationship (Type, Print)

Bernard J. Smith

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1218 Willow Road, Baltimore, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Geadens Of Faith

Date

6/2/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home, P.A.

1407 Old Eastern Avenue, Essex, Maryland 21221

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Non Hodgkin's Lymphoma
Due to (or as a consequence of):

9 mo.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) daughter's home

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

D45390

29d. Date signed (Month, Day, Year)

6/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6830 HOSPITAL DR. #206, BALTIMORE, MD 21237

State
Registrar

31. Date filed (Month, Day, Year)

JUN 2 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17646

| | | | | | | | | | | | |
|---|---|--|---|--|--|---|---|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Emma Isabelle Sherman | | | | | 2. Date of Death
Month May Day 28 Year 1999 | | 3. Time of Death
9:30 P.M. | | | |
| | 4a. Facility Name (If not institution, give street and number)
Stella Maris Hospice | | | | | 4b. City, Town, or Location of Death
Timonium | | 4c. County of Death
Baltimore | | | |
| Funeral
Director | 5. Social Security Number
233-32-4331 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
90 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 10, 1909 | | 9. Birthplace (State or Foreign Country)
West Virginia | | |
| | Usual Residence of Decedent | | | | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | 10e. Street and Number
5022 East Eager Street | | 10f. Zip Code
21205 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 3 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Seamstress |
| To Be Completed by Funeral Director | 16b. Kind of Business/Industry
Clothing Factory | | | | | 17. Father's Name (First, Middle, Last)
Warner Christian | | 18. Mother's Name (First, Middle, Maiden Surname)
Ada Borman | | 19a. Informant's Name/Relationship (Type, Print)
Lydia Jane Pfarr (daughter) | |
| | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6903 University Drive, Baltimore, Maryland 21220 | | | | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens Of Faith | | 20c. Location - City or Town, State
Baltimore, Maryland | |
| To Be Completed by Funeral Director | 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
Brzezinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Lung Cancer | | Approximate Interval Between Onset and Death | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | 29b. Signature and title of certifier
 | | 29c. License number
D43725 | | 29d. Date signed (Month, Day, Year)
6/1/99 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TARIQ MAHMOOD 821. N. Eutaw St. Baltimore MD 21201 | | | | | 31. Date filed (Month, Day, Year)
JUN 2 1999 | | 32. Registrar's Signature
 | | State Registrar | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17567

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Agatha Truglio

2. Date of Death

May 29, 1999

3. Time of Death

4:17pm

4a. Facility Name (If not institution, give street and number)

5118 Aver Court

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

089-16-8355

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug. 25, 1924

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5118 Aver Court

10f. Zip Code

21044

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Ralph Savignano

18. Mother's Name (First, Middle, Maiden Surname)

Jennie Clapso

19a. Informant's Name/Relationship (Type, Print)

Janet Quirk (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5118 Aver Court, Columbia, Maryland 21044

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National

Date

6/3/99

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Homes, Inc.

5555 Twin Knolls Road, Columbia, Maryland 21045

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC Lung Cancer to spleen and brain

Approximate Interval Between Onset and Death

10 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☒ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Nicholas W. Koutrelakos MD

29c. License number

D38509

29d. Date signed (Month, Day, Year)

June 1 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nicholas W. Koutrelakos 11065 Little Patuxent Pky Columbia MD 21044

31. Date filed (Month, Day, Year)

JUN 02 1999

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

AM 12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17648

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Louis Vanik

2. Date of Death

May 27 1999

3. Time of Death

09:05

4a. Facility Name (If not institution, give street and number)

University of Maryland Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

219-01-4415

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

April 29, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2916 East Baltimore Street

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Chauffer

16b. Kind of Business/Industry

Baltimore City

17. Father's Name (First, Middle, Last)

Thomas Vanik

18. Mother's Name (First, Middle, Maiden Surname)

Marie Bodecker

19a. Informant's Name/Relationship (Type, Print)

Earl T. Vanik (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3449 Yardly Drive, Baltimore, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Holly Hill Memorial Gar. 5/29/99

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

John W. Burkausk

22. Name and Address of Facility

Brudzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Renal Failure

Approximate Interval Between Onset and Death

two weeks

a. Due to (or as a consequence of):

Congestive Heart Failure

b. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Intracranial hemorrhage

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ann Cleverger MD

29c. License number

P11744

29d. Date signed (Month, Day, Year)

May 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ann Cleverger MD University of Maryland Hospital

31. Date filed (Month, Day, Year)

JUN 2 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

6+1

sent at 11

James P. Jones

1000 S. 10th

B.K.S

SOPHONIA AGNES WASHINGTON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: 1, 23 PART I, 27, 28A-F PER MEO G772 6-11-99 WR. Certificate of Death

Reg. No.

99 17649

| | | | | | | | | |
|---|--|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Sophonia Agnes Washington | | | | 2. Date of Death
Month MAY Day 25 Year 1999 | | 3. Time of Death
11:13 PM | |
| | 4a. Facility Name (If not institution, give street and number)
UNION MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
219-78-9972 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
39 Yrs. | | 8. Date of Birth (Month, Day, Year)
6 18 59 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
S.C. | | 10b. County
SHAW | | 10c. City, Town or Location
AFB | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
5142 A N Elder Dr. | | 10f. Zip Code
29152 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Nursing Home Care | | 16b. Kind of Business/Industry
Self-Employed | | | |
| | 17. Father's Name (First, Middle, Last)
Carroll Washington | | 18. Mother's Name (First, Middle, Maiden Surname)
Agnes Brown | | | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
Ellen Roper - Sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
927 Ellicott Drive Balto. Md. | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory | | 20c. Location - City or Town, State
6-2-99 Balto. Md. | | 20d. Location - City or Town, State | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
Jeff Miller | | 22. Name and Address of Facility
Jeff Miller P.C. Funeral Home & Services
1639 N. Broadway - Baltimore, Md. 21213 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
XX Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
XX Yes <input type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner?
XX Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
Found: 5-25-1999 | | 28b. Time of Injury
Found: 10:52 | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred
UNKNOWN | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) 1515 GORSUCH AVE. BALTIMORE, MD. | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
David K. Fowler | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
MAY 26, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David K. Fowler 111 Penn Street, Baltimore, Maryland 21201 | | 31. Data filed (Month, Day, Year)
JUN 2 1999 | | | | | |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature
B. Sparks | | 33. Data filed (Month, Day, Year)
JUN 2 1999 | | | | | |
| | 34. Registrar's Signature
B. Sparks | | 35. Data filed (Month, Day, Year)
JUN 2 1999 | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17650

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jane Washington

2. Date of Death

May 25, 1999

3. Time of Death

4:20 AM

4a. Facility Name (If not institution, give street and number)

Bayview Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

212-30-1597

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 28, 1931

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5009 Frankford Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: Black15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of workinglife. DO NOT use retired)
Homemaker

16b. Kind of Business/Industry

Private Families

17. Father's Name (First, Middle, Last)

Herbert E. Parker

18. Mother's Name (First, Middle, Maiden Surname)

Naomi Kuhn

19a. Informant's Name/Relationship (Type, Print)

Ms. Willene J. Smith Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2701 N. Rosedale Street Baltimore, Md. 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)
King Memorial Park

Date

June 1

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Herbert E. Nutter

22. Name and Address of Facility

Nutter Funeral Homes, Inc.
2501 Gwynns Falls PKWY Baltimore, Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. emphysema
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

pulmonary hypertension

coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gary Kozlow MD

29c. License number

D41617

29d. Date signed (Month, Day, Year)

May 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary Kozlow MD 10805 Hickory Ridge Rd Columbia Md 21048

31. Date filed (Month, Day, Year)

JUN 02 1999

32. Registrar's Signature

Denise B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

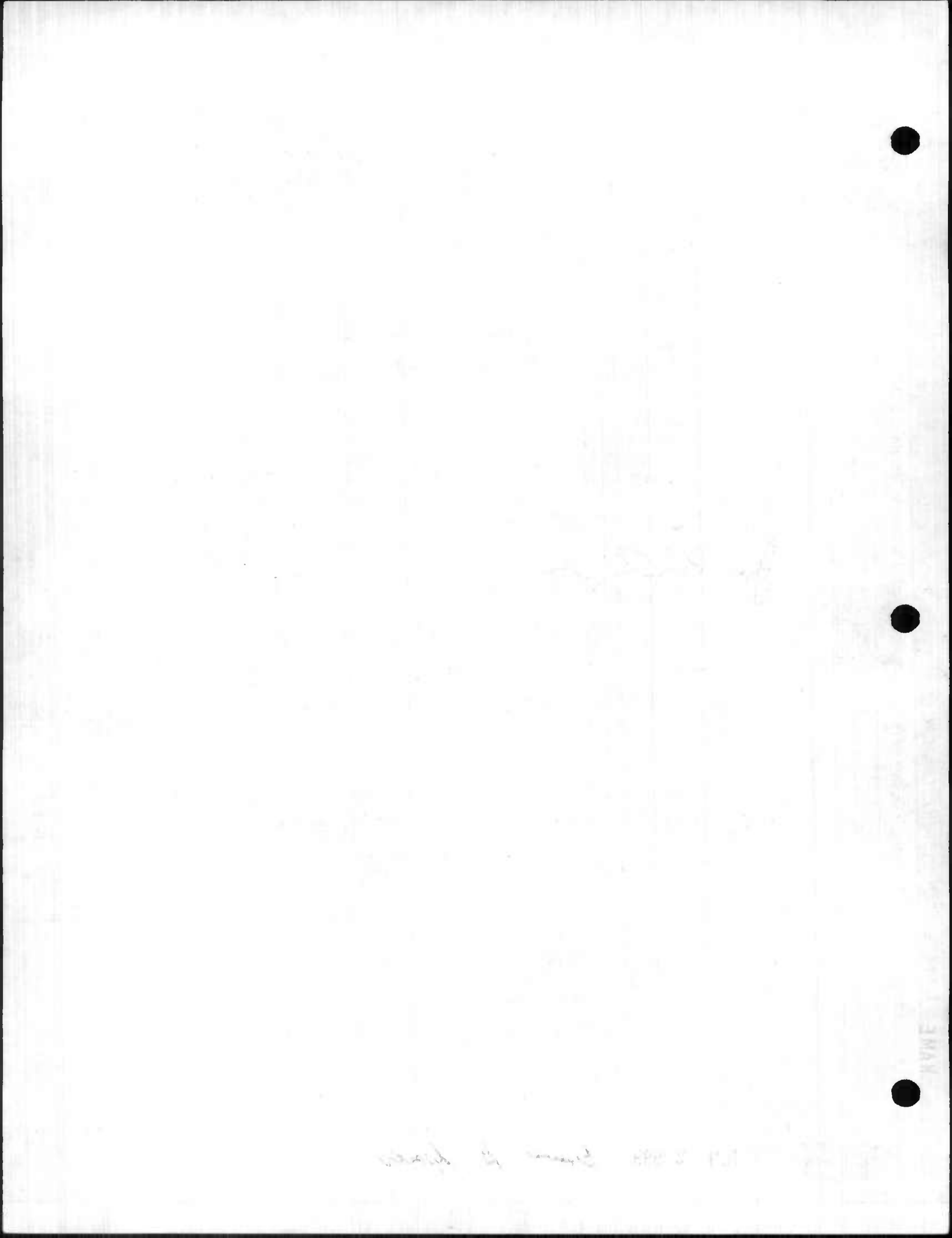
Certificate of Death

Reg. No.

99 17651

| | | | | | | | | |
|--|--|---|---|---|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Theodore A. Wilson, Jr. | | | | 2. Date of Death
Month Day Year
MAY 29 1999 | | 3. Time of Death
17:38 | |
| | 4a. Facility Name (If not institution, give street and number)
SAINT AGNES HEALTHCARE | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
220-24-7797 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
70 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Nov. 28, 1928 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10a. State
Maryland | | 10b. County
Baltimore | |
| | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number
4919 Eastern Avenue | | | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1946-1949 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Mechanic | | 16b. Kind of Business/Industry
Sheet Metal | | | |
| | 17. Father's Name (First, Middle, Last)
Theodore A. Wilson, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Zorada E. Still | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Jennie L. Wilson (wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4919 Eastern Avenue, Baltimore, Maryland 21224 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Wesley Chapel | | Date
6/3/99 | | 20c. Location - City or Town, State
Baltimore, Maryland | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Bruzdinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 | | | |
| | Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | |
| Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION | | | | | | | IMMEDIATE | |
| Due to (or as a consequence of):
b. PULMONARY EMBOLISM | | | | | | | ONE HOUR | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. DEEP VEIN THROMBOSIS | | | | | | | ONE WEEK | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE
PERIPHERAL VASCULAR DISEASE | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier

RESIDENT | | | | 29c. License number
P12596 | | 29d. Date signed (Month, Day, Year)
MAY 30, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KARTHIK MUTHUSAMY, 900 CATON AVENUE, BALTIMORE, MARYLAND 21229 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 2 1999 | | 32. Registrar's Signature
 | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17652

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ethel Zimmerman

2. Date of Death

Month Day Year
May 31, 1999

3. Time of Death

12:23pm

4a. Facility Name (If not institution, give street and number)

715 Maiden Choice Lane, Parkview 510

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-48-8219

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 25, 1905

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

715 Maiden Choice Lane, Parkview 510

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Marvin F. Birely

18. Mother's Name (First, Middle, Maiden Surname)

Alice Virginia (Moser)

19a. Informant's Name/Relationship (Type, Print)

Ann Z. Kulp (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5005 Andrea Ave Annandale, Va. 22003

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

6/5/99

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Homes, Inc.

1630 Edmondson Avenue, Catonsville, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

STROKE

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

MONTHS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PARKINSON'S

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Bernard F. Korlovsky MD

29c. License number

P26473

29d. Date signed (Month, Day, Year)

JUNE 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BERNARD F. KORLOVSKY, MD 711 MAIDEN CHOICE LANE,

State
Registrar

31. Date filed (Month, Day, Year)

JUN 02 1999

32. Registrar's Signature

Bernard F. Korlovsky

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#26 perPhyG772 6/2/99 EW

Certificate of Death

Reg. No. 99 17652

| | | | | | | | | |
|---|--|--|---|--|---|--------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Stephen Zyla</i> | | | | 2. Date of Death
Month <i>05</i> Day <i>25</i> Year <i>1999</i> | | 3. Time of Death
<i>8:42 p.m.</i> | |
| | 4e. Facility Name (If not institution, give street and number)
<i>1418 Midvale Avenue</i> | | | | 4b. City, Town, or Location of Death
<i>Catonsville</i> | | 4c. County of Death
<i>Baltimore</i> | |
| Funeral
Director | 5. Social Security Number
<i>178-05-0636</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>86</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>12/26/1912</i> | |
| | 9. Birthplace (State or Foreign Country)
<i>PA</i> | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | | |
| | 10a. State
<i>Md</i> | | 10b. County
<i>N/A</i> | | 10c. City, Town or Location
<i>Baltimore</i> | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
<i>619 Yale Avenue</i> | | | | 10f. Zip Code
<i>21229</i> | | 10g. Citizen of What Country?
<i>USA</i> | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: <i>42-45</i> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>white</i> | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>8</i> College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Plastics Laborer</i> | | 16b. Kind of Business/Industry
<i>Western Electric</i> | |
| | 17. Father's Name (First, Middle, Last)
<i>Valenty Zyla</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Mary Anna Orzech</i> | | | |
| | 19e. Informant's Name/Relationship (Type, Print)
<i>Patricia Zyla/Daughter</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>1418 Midvale Avenue, Catonsville, Md. 21228</i> | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>New Cathedral Cemetery</i> | | Date
<i>5/29</i> | | 20c. Location - City or Town, State
<i>Baltimore, Md.</i> | |
| | 21. Signature of Funeral Service Licensee
<i>Robert C. Lewis</i> | | | | 22. Name and Address of Facility
<i>Sterling-Ashton-Schwab Funeral Home, Inc
736 Edmondson Avenue, Balto, Md 21228</i> | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <i>myelodysplastic syndrome</i>
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | |
| Approximate interval Between Onset and Death
<i>months</i> | | | | | | | | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>Daughter's Residence</i> | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier
<i>Laurena R. Gallagher MD</i> | | | | 29c. License number
<i>D01786</i> | | 29d. Date signed (Month, Day, Year)
<i>May 27, 1999</i> | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Laurence Gallagher MD 716 Maiden Creek Lane, Balto MD 21218</i> | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
<i>JUN - 2 1999</i> | | | | 32. Registrar's Signature
<i>B. Sparks</i> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17654

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nicole Brooke Adkins

2. Date of Death

Month Day Year
APRIL 13 1999

3. Time of Death

10:46PM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Baltimore

5. Social Security Number

None

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6

8. Date of Birth

(Month, Day, Year)

April 13, 1999 Maryland

9. Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline County

10c. City, Town or Location

Denton

10e. Street and Number

205 South Second Street

10f. Zip Code

21629

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Native American/
Specify: Caucasian

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
None

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

None

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Leonard Dale Adkins, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Stephanie Louise Kinsey

19a. Informant's Name/Relationship (Type, Print)

Parents
Leonard Dale and Stephanie Adkins

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

205 South Second Street, Denton, Maryland 21629

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chester Cemetery

Date

4/16/99 Chestertown, Maryland

21. Signature of Funeral Service Licensee

► *Rudolph P. Moore*

22. Name and Address of Facility

Moore Funeral Home, P.A.
12 South Second Street, Denton, Maryland 21629

Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Complex Congenital heart disease*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 hours

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Respiratory distress Syndrome

Prematurity

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► *Wendy B. Roberts*

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

4/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wendy Roberts, Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, MD 21287

31. Date filed (Month, Day, Year)

APR 16 1999

32. Registrar's Signature

Anna B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ADH
TERI BURKHOLDER
99-3048-041

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 17655

ITEMS: #23 PART I, 27, 28A-F PER MEO G772 6-9-99 WR. Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Teresa Lynn Burkholder | | | | 2. Date of Death
Month Day Year
MAY 26, 1999 | | 3. Time of Death
1830 PM | | | | | | | |
| | 4a. Facility Name (If not Institution, give street and number)
4787 BLACK WALNUT POINT | | | | 4b. City, Town, or Location of Death
TILGHMAN | | 4c. County of Death
TALBOT | | | | | | | |
| Funeral
Director | 5. Social Security Number
215-90-5885 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
32 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
2/11/1967 | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Talbot | | 10c. City, Town or Location
Tilghman | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| | 10e. Street and Number
21521 Gibson Town Rd. | | | | 10f. Zip Code
21671 | | 10g. Citizen of What Country?
USA | | | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Communication | | | 16b. Kind of Business/Industry
Engineer | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Arnold Somers | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Patricia Bates | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
John Henry Burkholder (spouse) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11667 Charter Oak Ct., apt. 202, Reston, VA 20190 | | | | | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Salisbury Crematory | | Date
5/28/99 | | 20c. Location - City or Town, State
Salisbury, Maryland | | | | | | | |
| | 21. Signature of Funeral Service Licensee
Michael A Dean MU1129 | | 22. Name and Address of Facility
Holloway Funeral Home
501 Snow Hill Rd., Salisbury, MD 21804 | | | | | | | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ANOXIA
Due to (or as a consequence of):
b. INHALATION OF DIFLUOROETHANE AND PLASTIC BAG OVER HEAD
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
Found: 5-26-99 | | 28b. Time of Injury
Found: 3:30 P M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
SUBJECT INHALED AND HAD PLACED PLASTIC BAG OVER HEAD | | | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
FOUND: RESIDENCE | | | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
FACE 4787 BLACKWALNUT ROAD TILGHMAN, MARYLAND | | | | | |
| | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | 29b. Signature and title of certifier
Wayne Burkholder am | | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
MAY 27, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mary Davis Koron 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | 31. Date filed (Month, Day, Year)
MAY 28 1999 | | 32. Registrar's Signature
B Sparks | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Handwritten signature or initials

RECEIVED

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17656

Physician
/Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0020

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

| | | | | | | | |
|--|--|---|---|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)
John Davis Bilbrough | | | | 2. Date of Death
Month Day Year
May 11 1999 | | 3. Time of Death
8:40 p | |
| 4a. Facility Name (If not institution, give street and number)
Shore Nursing & Rehab Center | | | | 4b. City, Town, or Location of Death
Denton | | 4c. County of Death
Caroline | |
| 5. Social Security Number
219-05-5206 | | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
85 | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Dec. 6 1913 | |
| 9. Birthplace (State or Foreign Country)
Maryland | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Caroline | | 10c. City, Town or Location
Greensboro | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
26960 Bilbrough Road | | | | 10f. Zip Code
21639 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 yrs
College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
milk transporter | | 16b. Kind of Business/Industry
dairy industry | |
| 17. Father's Name (First, Middle, Last)
John A. Bilbrough | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Nellie Bishop Bilbrough | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Della Mae Bilbrough/ wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
26960 Bilbrough Road Greensboro, MD 21639 | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greensboro Cemetery | | Date
5/16 | | 20c. Location - City or Town, State
Greensboro, Maryland | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Fleegle & Helfenbein Funeral Home, PA
P.O. Box 160 Greensboro, MD 21639 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Cerebrovascular accident

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

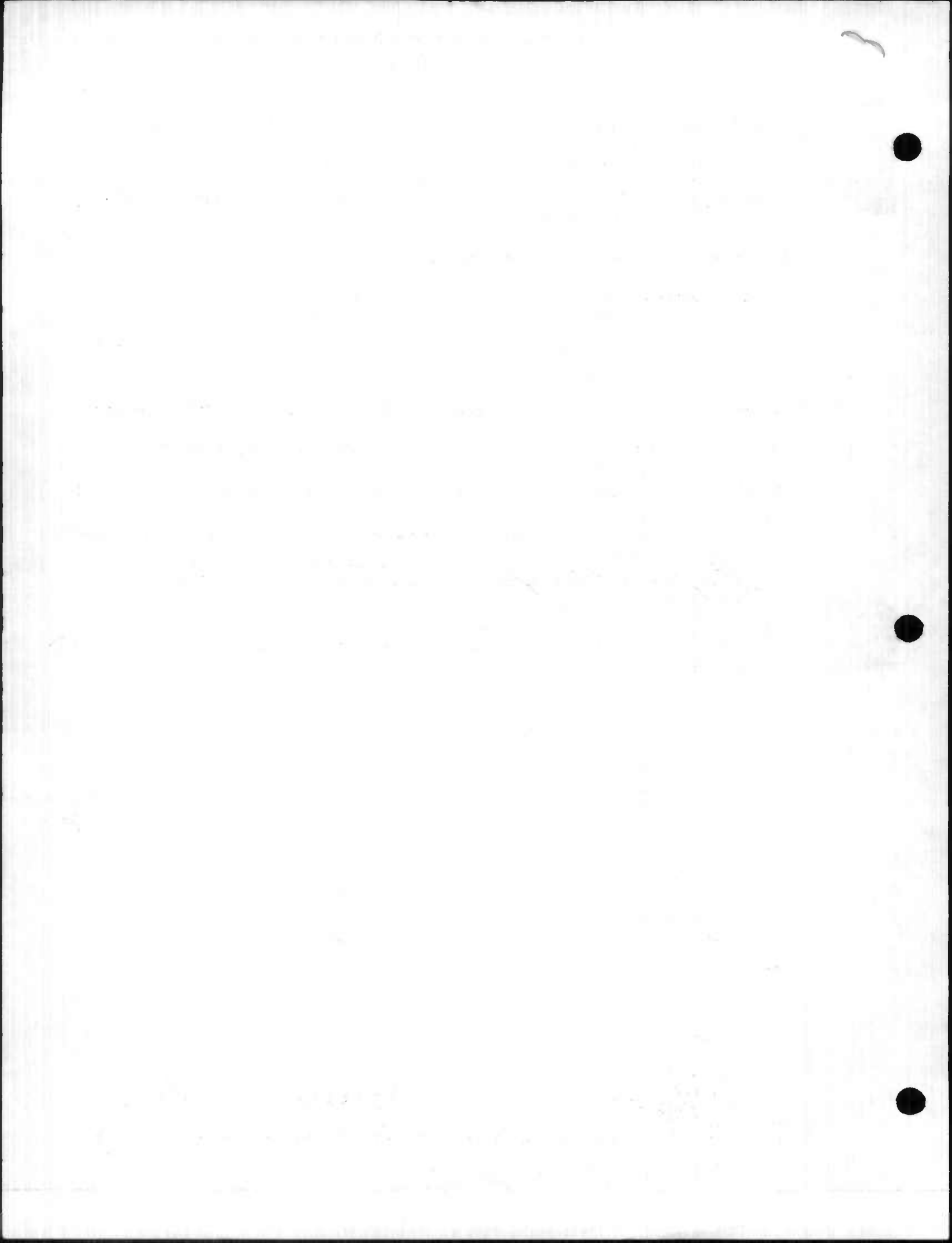
Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death
6m | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | | | | |
| | | 29c. License number
032036 | | 29d. Date signed (Month, Day, Year)
5/12/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Gary J. Spruill 2108 N. Donahoe Drive Chester, MD 21619 | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1999 | | 32. Registrar's Signature
 | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #11 PER WIFE G774 8-12-99 W State of Maryland / Department of Health and Mental Hygiene

99 17657

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE AMBROSE BOCH

2. Date of Death

Month Day Year
May 25, 1999

3. Time of Death

7:20 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Lions Manor Nursing Home

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

217-10-7293

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
8/23/19

9. Birthplace (State or Foreign Country)

CUMBERLAND, MD

Usual Residence of Decedent

10e. State

MD

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

235 PACA STREET, QUEEN CITY TOWERS

10f. Zip Code

21502

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10

College (1-4or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

BUSINESS OWNER

16b. Kind of Business/Industry

TRUCKING

17. Father's Name (First, Middle, Last)

GEORGE HENRY BOCH

18. Mother's Name (First, Middle, Maiden Surname)

FRANCES RUTH BURKEY BOCH

19e. Informant's Name/Relationship (Type, Print)

WVU HGR

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 9128, MORGANTOWN, WV 26506

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

OMEGA CREMATORY

Date

5/26/99

20c. Location - City or Town, State

MORGANTOWN, WV

21. Signature of Funeral Service Licensee

Michael G. G. G.

22. Name and Address of Facility

WVU HGR

P.O. BOX 9128, MORGANTOWN, WV 26506

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Cerebrovascular Accident with complications 7 years

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28e. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

P. Snow

29c. License number

D09157

29d. Date signed (Month, Day, Year)

May 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. Snow, M.D., 124 West 3rd Street, Cumberland, MD 21502

31. Date filed (Month, Day, Year)

MAY 26 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23c or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

THOMAS LUTHER
CARROLL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17658

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 25a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760;

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)
THOMAS LUTHER CARROLL, JR. | | 2. Date of Death
Month Day Year
APRIL 28, 1999 | | 3. Time of Death
21:50 PM | |
| 4a. Facility Name (If not institution, give street and number)
CALVERT MEMORIAL HOSPITAL | | | 4b. City, Town, or Location of Death
PRINCE FREDERICK | | 4c. County of Death
CALVERT |
| 5. Social Security Number
218-98-8351 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
31 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
OCT. 9, 1967 |
| 9. Birthplace (State or Foreign Country)
MARYLAND | | | | | |
| 10a. State
MARYLAND | | 10b. County
CALVERT | | 10c. City, Town or Location
NORTH BEACH | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number
8690 Chesapeake Lighthouse Drive | | | 10f. Zip Code
20714 | | 10g. Citizen of What Country?
U. S. A. |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) POLICE OFFICER | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
POLICE OFFICER | | 16b. Kind of Business/Industry
POLICE DEPARTMENT | | | |
| 17. Father's Name (First, Middle, Last)
THOMAS LUTHER CARROLL, SR. | | | 18. Mother's Name (First, Middle, Maiden Surname)
RHETTA SOMERS | | |
| 19a. Informant's Name/Relationship (Type, Print)
THOMAS L. CARROLL, SR./FATHER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11101 LYNFORD CT. UPPER MARLBORO, MARYLAND 20772 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. PAUL'S CHURCH CEMETERY | | 20c. Location - City or Town, State
MAY 5, 1999 LUSBY, MARYLAND | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
LEE FUNERAL HOME CALVERT, P.A.
8125 SOUTHERN MARYLAND BLVD. OWINGS, MD 20736 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
DILATED CARDIOMYOPATHY
a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
MORBID OBESITY | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier
(Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
APRIL 29, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 07 1999 | | 32. Registrar's Signature
 | | | |

ORIGINAL

99 17659

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Stella Mae Cannon | | | | 2. DATE OF DEATH
MONTH DAY YEAR
April 14 1999 | | 3. TIME OF DEATH
3:00 A M | |
| 4. SOCIAL SECURITY NUMBER
213-18-4563 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
June 19, 1922 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
10675 Greensboro Road | | 9b. CITY, TOWN OR LOCATION OF DEATH
Denton | |
| 9c. COUNTY OF DEATH
Caroline | | | | 10a. STATE
Maryland | | 10b. COUNTY
Caroline | |
| 10c. CITY, TOWN OR LOCATION
Denton | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
10675 Greensboro Road | |
| 10f. ZIP CODE
21629 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 HS Grad.
College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Technician | | 16b. KIND OF BUSINESS/INDUSTRY
Laboratory | |
| 17. FATHER'S NAME (First, Middle, Last)
Robert Moore Brubaker | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Marguerite Anise Wyatt | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Sandra Parson Daughter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10675 Greensboro Road, Denton, Maryland 21629 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Denton Cemetery | | 20c. LOCATION — City or Town, State
Denton, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Robert K. Moore</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Moore Funeral Home, P.A. 21629
12 South Second Street, Denton, Maryland | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Colon Ca
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate interval between Onset and Death
<1 year |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Osteoarthritis, Trigeminal Neuralgia | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Joan D.O.</i> | | | | 29c. LICENSE NUMBER
H 44615 | | 29d. DATE SIGNED (Month, Day, Year)
4/16/99 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Lois Narr, D.O., 2 Aurora Street, Cambridge, Maryland 21613 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
APR 20 1999 | | | | 32. REGISTRAR'S SIGNATURE
<i>B. Sparks</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17660

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALBERT S. COUGHENOUR

2. Date of Death

April 1, 1999

3. Time of Death

0345

4a. Facility Name (If not institution, give street and number)

2642 Choptank Main Street

4b. City, Town, or Location of Death

Preston

4c. County of Death

Caroline

Funeral
Director

5. Social Security Number

217-09-5352

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

10/23/12

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Caroline

10c. City, Town or Location

Preston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2642 Choptank Main Street

10f. Zip Code

21655

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
3

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Proprietor

16b. Kind of Business/Industry

Country Store

17. Father's Name (First, Middle, Last)

John Coughenour

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Woolford

19a. Informant's Name/Relationship (Type, Print)

Audrey B. Coughenour/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2642 Choptank Main St., Preston, MD 21655

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Choptank Cemetery

Date

4/3

20c. Location - City or Town, State

Choptank, Maryland

21. Signature of Funeral Service Licensee

Michael F. Eskew

22. Name and Address of Facility

Frampton-Hawkins-Eskow Funeral Home, PA
PO Box 43, Federalsburg, MD 21632

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. AORTIC STENOSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John R. Condit

29c. License number

H41416

29d. Date signed (Month, Day, Year)

4/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John R. Condit, M.D., 403 Marvel Court, MD 21601

31. Date filed (Month, Day, Year)

APR 13 1999

32. Registrar's Signature

Sparks

State
Registrar

Baltimore, Maryland 21215-0020

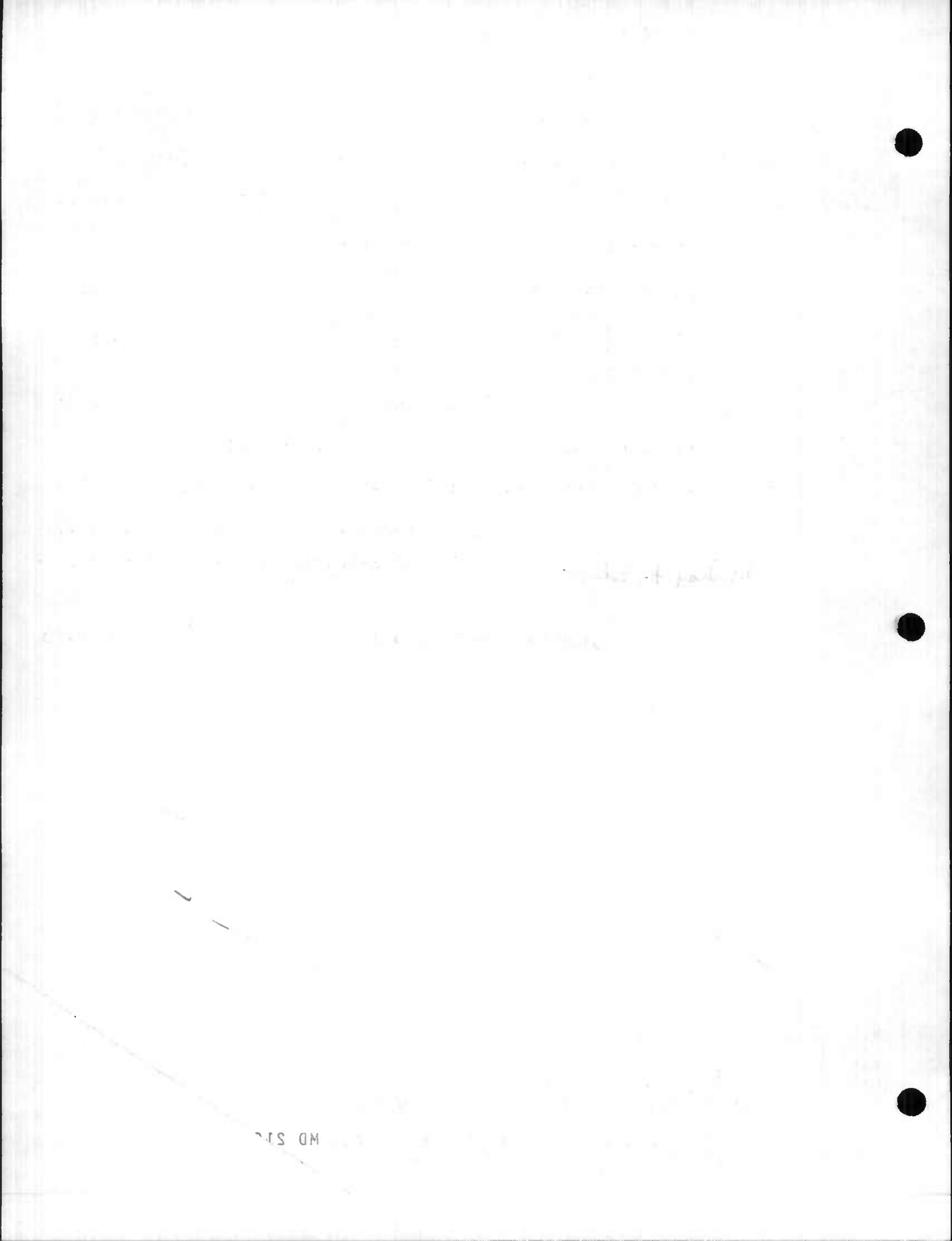
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



MD S1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17661

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
Kennard Carl Cook | | | | 2. Date of Death
Month 05 Day 05 Year 99 | | 3. Time of Death
3:18PM | |
| 4a. Facility Name (If not institution, give street and number)
CAROLINE NURSING HOME, INC. | | | | 4b. City, Town, or Location of Death
DENTON | | 4c. County of Death
CAROLINE | |
| 5. Social Security Number
214-12-6379 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
82 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 21, 1917 | |
| 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Caroline | | 10c. City, Town or Location
Ridgely | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
209 Maple Avenue | | 10f. Zip Code
21660 | | 10g. Citizen of What Country?
United States | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify:
Caucasian | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9
Collage (1-4or 5+) Collage | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Truck Driver/Sales Manager | | 16b. Kind of Business/Industry
Beverage Company | | 17. Father's Name (First, Middle, Last)
Joseph Linwood Cook | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Mary Etta Elliott | | 19a. Informant's Name/Relationship (Type, Print)
Ida Catherine Cook Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PO Box 374, Ridgely, Maryland 21660 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Nema of cemetery, crematory or other place)
Ridgely Cemetery | | 20c. Location - City or Town, State
5/8/99 Ridgely, Maryland | | 21. Signature of Funeral Service Licensee
<i>Charles H. Cook</i> | | 22. Name and Address of Facility
Moore Funeral Home, P.A.
12 South Second Street, Denton, Maryland 21629 | |
| 23a. Immediate Cause (Final disease or condition resulting in death)
Sepsis
Due to (or as a consequence of): | | 23b. Sequence of conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
gangrene - Foot
Due to (or as a consequence of):
peripheral Vascular disease
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
Days
weeks | | 23c. Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cerebrovascula Accident | |
| 23d. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>James Siles MD</i> | | 29c. License number
D31376 | | 29d. Date signed (Month, Day, Year)
5-7-99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
James Siles 920 Market St Denton MD 21629 | | 31. Date filed (Month, Day, Year)
MAY 7 - 1999 | | 32. Registrar's Signature
<i>Benjamin P. Sparks</i> | | | |

State
Registrar

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
HARRIET LOUISE CULP | | 2. DATE OF DEATH
MONTH DAY YEAR
May 14, 1999 | | 3. TIME OF DEATH
7 P M | |
| 4. SOCIAL SECURITY NUMBER
295-10-7995 | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
78 YRS. | 7. DATE OF BIRTH
(Month, Day, Year)
03-03-1921 | | 8. BIRTHPLACE (State or Foreign Country)
Ohio |
| 9a. FACILITY NAME (If not institution, give street and number)
405 Glebe Road | | 9b. CITY, TOWN OR LOCATION OF DEATH
Easton | | 9c. COUNTY OF DEATH
Talbot | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE
Md. | 10b. COUNTY
Talbot | 10c. CITY, TOWN OR LOCATION
Easton | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
405 Glebe Road | | 10f. ZIP CODE
21601 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Bookkeeper | | 16b. KIND OF BUSINESS/INDUSTRY
Retail Department Store | |
| 17. FATHER'S NAME (First, Middle, Last)
Frank Robert Schutt | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Grace Florence Schoof | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Judith Carey-Tracy | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
405 Glebe Rd., Easton, Md. 21601 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Capital Crematory | | 20c. LOCATION — City or Town, State
5/16 Dover, Delaware | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Randolph Moore</i> | | 22. NAME AND ADDRESS OF FACILITY
Moore Funeral Home, P.A.
12 S. 2nd St., Denton, Md. 21629 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Carcinoma of the Tongue
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate Interval Between Onset and Death
4 yrs |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive lung Disease | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY
M | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 28d. DESCRIBE HOW INJURY OCCURRED |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>William H Wood Jr MD</i> | | | 29c. LICENSE NUMBER
D08715 | 29d. DATE SIGNED (Month, Day, Year)
5/15/99 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
William H. Wood, Jr., M.D., 506 Idlewild Ave., Easton, Maryland 21601 | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 18 1999 | | 32. REGISTRAR'S SIGNATURE
<i>Geneva S. Sparks</i> | | | |

check by mail 2/24/54

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17663

| | | | | | | | | | |
|--|---|---|---|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Edna Mae Chalupa | | | | 2. Date of Death
Month May Day 14 Year 1999 | | 3. Time of Death
8:35 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
Caroline Nursing Home, Inc. | | | | 4b. City, Town, or Location of Death
Denton | | 4c. County of Death
Caroline | | |
| Funeral
Director | 5. Social Security Number
159-38-6498 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
91 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
September 22, 1907 | 9. Birthplace (State or Foreign Country)
Pennsylvania | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Caroline | | 10c. City, Town or Location
Denton | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number
5 South Sixth Street | | | | 10f. Zip Code
21629 | | 10g. Citizen of What Country?
United States | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify:
Caucasian | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 HS Grad. | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Home | | | | |
| | 17. Father's Name (First, Middle, Last)
Edward Zoeller | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Anna West | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Gail Weissert Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
23627 Willow Pond Road, Denton, Maryland 21629 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Allegheny Memorial Park | | Date
5/19 | | 20c. Location - City or Town, State
Allison Park, Pennsylvania | | |
| | 21. Signature of Funeral Service Licensee
<i>Randolph P. Moore</i> | | | | 22. Name and Address of Facility
Moore Funeral Home, P.A.
12 South Second Street, Denton, Maryland 21629 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown

24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Alzheimer's dementia | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Wafik Zaki M.D.</i> | | 29c. License number
047534 | | 29d. Date signed (Month, Day, Year)
5/17/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wafik Zaki, M.D., 920 Market Street, PO Box 496, Denton, Maryland 21629 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 18 1999 | | 32. Registrar's Signature
<i>Barbara B. Sparks</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17664

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Grace Muriel Dadds

2. Date of Death

Month
MayDay
20Year
1999

3. Time of Death

7:00 AM

4a. Facility Name (If not institution, give street and number)

446 Railroad Ave.

4b. City, Town, or Location of Death

Centreville

4c. County of Death

Queen Anne

5. Social Security Number

219-07-7116

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec 21 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Queen Anne

10c. City, Town or Location

Centreville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

446 Railroad Ave.

10f. Zip Code

21617

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
7 yrs

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

David E. Baynard

18. Mother's Name (First, Middle, Maiden Surname)

Carrie E. Strannahan Baynard

19a. Informant's Name/Relationship (Type, Print)

Violet Pinder/ sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

128 Kidwell Ave. Centreville, MD 21617

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Greensboro Cemetery

Date

5/24

20c. Location - City or Town, State

Greensboro, Maryland

21. Signature of Funeral Service Licensee

Fleagle & Helfenbein Funeral Home, PA
P.O. Box 160 Greensboro, MD 21639

22. Name and Address of Facility

Fleagle & Helfenbein Funeral Home, PA
P.O. Box 160 Greensboro, MD 2163923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. SUDDEN DEATH
Due to (or as a consequence of):b. CORONARY ARTERY DISEASE
Due to (or as a consequence of):c. CARDIAC DYRHYTHMIA
Due to (or as a consequence of):

d. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral VASC. DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Dr. Eric Ciganek, M.D.

29c. License number

D35243

29d. Date signed (Month, Day, Year)

5/21/94

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Eric Ciganek, 109 S. Commerce St., Centreville, MD 21617

31. Date filed (Month, Day, Year)

MAY 24 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

99 17665

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Katharine Everngam | | 2. DATE OF DEATH
MONTH DAY YEAR
April 8 1999 | | 3. TIME OF DEATH
11:05 P.M. | |
| 4. SOCIAL SECURITY NUMBER
218-58-1157 | | 5. SEX
1 M 2 F | | 6. AGE (In yrs. last birthday)
88 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year)
October 5, 1910 | | 8. BIRTHPLACE (State or Foreign Country)
West Virginia | | 9a. FACILITY NAME (If not institution, give street and number)
100 Ellerslie Court | |
| 9b. CITY, TOWN OR LOCATION OF DEATH
Denton | | 9c. COUNTY OF DEATH
Caroline | | 10a. STATE
Maryland | |
| 10b. COUNTY
Caroline | | 10c. CITY, TOWN OR LOCATION
Denton | | 10d. INSIDE CITY LIMITS?
1X YES 2 NO | |
| 10e. STREET AND NUMBER
100 Ellerslie Court | | 10f. ZIP CODE
21629 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
3X Widowed | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 YES 2X NO | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2X NO | |
| 14. RACE — American Indian, Black, White, etc.
Caucasian | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | |
| 16b. KIND OF BUSINESS/INDUSTRY
Home | | 17. FATHER'S NAME (First, Middle, Last)
R. Lucien Reinhart | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Katharine Schober | |
| 19a. INFORMANT'S NAME (Type/Print)
K. Thomas Everngam, Jr. son | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7886 Avon Court, Easton, Maryland 21601 | | 20a. METHOD OF DISPOSITION
2X Burial | |
| 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Concord Cemetery | | 20c. LOCATION — City or Town, State
4/12 near Denton, Maryland | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Randolph Moore | |
| 22. NAME AND ADDRESS OF FACILITY
Moore Funeral Home, P.A. 21629 | | 22. NAME AND ADDRESS OF FACILITY
12 South Second Street, Denton, Maryland | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
CEREBROVASCULAR INSUFFICIENCY ACUTE
CEREBROVASCULAR INSUFFICIENCY CHRONIC PROGRESSIVE (2 YEARS) | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 YES 2X NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 YES 2 NO | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 YES 2X NO | |
| 26. PLACE OF DEATH (Check only one)
1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) | | 27. MANNER OF DEATH
1X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
M 1 YES 2 NO | |
| 28c. INJURY AT WORK?
1 YES 2 NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Christian E. Jensen M.D. | | 29c. LICENSE NUMBER
D14664 | |
| 29d. DATE SIGNED (Month, Day, Year)
4/13/99 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Christian E. Jensen, M.D., PO Box 690, Denton, Maryland 21629 | | 31. DATE FILED (Month, Day, Year)
APR 14 1999 | |
| 32. REGISTRAR'S SIGNATURE
[Signature] | | 33. REGISTRAR'S SIGNATURE
[Signature] | | 34. REGISTRAR'S SIGNATURE
[Signature] | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

APR 19 1974

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17666

| | | | | | | | | | | | |
|--|---|--|---|--|--|--|---|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Wilson Dennis Edwards | | | | | 2. Date of Death
Month Day Year
APRIL 15, 1999 | | 3. Time of Death
5:20 PM. | | | |
| | 4a. Facility Name (If not institution, give street and number)
MEMORIAL HOSPITAL | | | | | 4b. City, Town, or Location of Death
EASTON | | 4c. County of Death
Talbot | | | |
| Funeral
Director | 5. Social Security Number
212-40-9738 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
57 Yrs. | | 8. Date of Birth (Month, Day, Year)
11-16-41 | | 9. Birthplace (State or Foreign Country)
Md. | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
Md. | | | 10b. County
Caroline | | 10c. City, Town or Location
Greensboro | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
12306 Greensboro Rd. | | | | | 10f. Zip Code
21639 | | 10g. Citizen of What Country?
U.S.A. | | | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1970 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laborer | | | 16b. Kind of Business/Industry
Chem. Manufactuer | | | |
| 17. Father's Name (First, Middle, Last)
Harlan Edwards | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Eva Dennis Edwards | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Rosalie Kelly | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box R Felton Del. 19943 | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Eastern Shore Vet. Cem. | | Date
4-22-99 | | 20c. Location - City or Town, State
Hurlock Md. | | | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | | 22. Name and Address of Facility
Fleegle-Helfenbein 106 Sunset Ave. Greensboro | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <i>Stab Wounds of Neck</i>
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown

24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No

24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year)
<i>4-15-99</i> | | 28b. Time of Injury
<i>1400</i> M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
<i>self inflicted stab wound</i> | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier
<i>[Signature]</i> | | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
APRIL 16, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Dennis J. Chute</i> 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
APR 20 1999 | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17667

| | | | | | | | | | | | | | | | | |
|--|---|---|--|--|--|--|--|--|---|--|---------|---|---------|---|---------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES E. FORREST | | | | 2. Date of Death
Month 5 Day 2 Year 1999 | | 3. Time of Death
2:23 PM | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
VAMC BALTIMORE | | | | 4b. City, Town, or Location of Death
BALTIMORE, MD | | 4c. County of Death
BALTIMORE | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
219-01-4777 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
76 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
11-10-1922 | 9. Birthplace (State or Foreign Country)
INDIANA | | | | | | | | |
| | Usual Residence of Decedent | | | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State
Maryland | | 10b. County
Baltimore | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
United States | | | | | | | | | |
| | 10e. Street and Number
404 Overview Avenue | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
United States | | | | | | | | | | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1942-1945 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify:
Caucasian | | | | | | | | | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4or 5+) | | 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Industrial Engineer | | 16b. Kind of Business/Industry
Engineering | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
William Henry Forrest | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lovey Elizabeth Skidmore | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Gertrude Bauernfiend Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
404 Overview Avenue, Baltimore, Maryland 21224 | | | | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Denton Cemetery | | Date
5/5/99 | | 20c. Location - City or Town, State
Denton, Maryland | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
<i>Randolph P. Moore</i> | | | | 22. Name and Address of Facility
Moore Funeral Home, P.A.
12 South Second Street, Denton, Maryland 21629 | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. Sepsis
Due to (or as a consequence of):</td> <td>17 days</td> </tr> <tr> <td>b. Acute renal failure
Due to (or as a consequence of):</td> <td>16 days</td> </tr> <tr> <td>c. Cumulative oxygen deficit
Due to (or as a consequence of):</td> <td>17 days</td> </tr> <tr> <td>d. Gallstone ileus s/P enterotomy
Due to (or as a consequence of):</td> <td>20 days</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Sepsis
Due to (or as a consequence of): | 17 days | b. Acute renal failure
Due to (or as a consequence of): | 16 days | c. Cumulative oxygen deficit
Due to (or as a consequence of): | 17 days | d. Gallstone ileus s/P enterotomy
Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Sepsis
Due to (or as a consequence of): | 17 days | | | | | | | | | | | | | | |
| | b. Acute renal failure
Due to (or as a consequence of): | 16 days | | | | | | | | | | | | | | |
| | c. Cumulative oxygen deficit
Due to (or as a consequence of): | 17 days | | | | | | | | | | | | | | |
| | d. Gallstone ileus s/P enterotomy
Due to (or as a consequence of): | 20 days | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CAD, CHF
COPD
Hx prostate CA | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28e. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 28e. Piece of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Winfred Fong MD</i> | | | | 29c. License number
PGY1-Resident | | 29d. Date signed (Month, Day, Year)
5/2/99 | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Winfred Fong, M.D. UMMS, Dept. of Surgery, 22 S. Greene St, Balt MD 21201 | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 4 - 1999 | | 32. Registrar's Signature
<i>B. Sparks</i> | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17668

| | | | | | | | | | | |
|--|--|--|---|--|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Hazel E. Greene | | | | 2. Date of Death
Month Day Year
April 13 1999 | | | | 3. Time of Death
2:00 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Love and Care Home | | | | 4b. City, Town, or Location of Death
Greensboro | | | | 4c. County of Death
Caroline | |
| Funeral
Director | 5. Social Security Number
212-12-3918 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 11 1920 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Caroline | | 10c. City, Town or Location
Greensboro | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
12691 Greensboro Road | | | | 10f. Zip Code
21639 | | 10g. Citizen of What Country?
U.S.A. | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
seamstress | | | 16b. Kind of Business/Industry
manufacturing | | |
| | 17. Father's Name (First, Middle, Last)
Norman Hutson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ruth Clough Hutson | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Janet L. Parks/ granddaughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
18717 Templeville Rd. Marydel Md. 21649 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greensboro Cemetery | | Date
4/16 | | 20c. Location - City or Town, State
Greensboro, Maryland | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Fleegle & Helfenbein Funeral Home, PA
P.O. Box 160 Greensboro, MD 21639 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. myocardial infarction minutes
Due to (or as a consequence of):
b. coronary artery disease years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
cerebrovascular accident
diabetes Mellitus | | | | | | | | | |
| Physician
/Medical
Examiner | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier
 | | | | 29c. License number
MD. 047534 | | 29d. Date signed (Month, Day, Year)
4/14/99 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wafiq I Zaki, M.D. 920 Market St Denton MD 21629 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
APR 15 1999 | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17669

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alexander Henry Geleno

2. Date of Death

April 25 1999

3. Time of Death

4:00PM

4a. Facility Name (If not institution, give street and number)

VA Maryland Health Care System

4b. City, Town, or Location of Death

Perry Point

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

060-22-1032

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 11, 1915

9. Birthplace (State or Foreign Country)

Canada

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Denton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9460 Fisher Road

10f. Zip Code

21629

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1944-

1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Caucasian

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

Brakeman and conductor

16b. Kind of Business/Industry

Railroad Systems

17. Father's Name (First, Middle, Last)

Nicholas Geleno

18. Mother's Name (First, Middle, Maiden Surname)

Clorinda Florence Natale

19a. Informant's Name/Relationship (Type, Print)

Marilyn Weinrich

Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9460 Fisher Road, Denton, Maryland 21629


20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Maryland Eastern Shore
Veterans' Cemetery

Date

4/29/99 Beulah, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Moore Funeral Home, P.A.

12 South Second Street, Denton, Maryland 21629

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

Pneumonia

Approximate
Interval Between
Onset and Death

24 hours

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary Disease

20 years

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

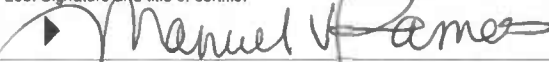
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D38950

29d. Date signed (Month, Day, Year)

4/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manuel Ramos, M.D. VA Maryland Health Care System, Perry Point, MD 21902

31. Date filed (Month, Day, Year)

APR 29 1999

32. Registrar's Signature

State
Registrar

NAME KNOWN TO PHYSICIAN: GELENO, ALEXANDER

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Division of Vital Records, P.O. Box 68760,

the first of the year
the first of the year
the first of the year

the first of the year
the first of the year
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the first of the year



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17670

Physician
(Medical
Examiner)

1. Decedent's Name (First, Middle, Last)

Harry T. Haywood

2. Date of Death

Month Day Year
04 16 99

3. Time of Death

1243

4a. Facility Name (If not institution, give street and number)

University of Maryland Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral
Director

5. Social Security Number

086-30-9908

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

58

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 12 1940

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Denton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

322 Deep Shore

10f. Zip Code

21629

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 58-61

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12 yCollege (1-4 or 5+)
5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

school teacher

16b. Kind of Business/Industry

& marine diesel mechanics

17. Father's Name (First, Middle, Last)

John Haywood

18. Mother's Name (First, Middle, Maiden Surname)

Leah Clute Haywood

19a. Informant's Name/Relationship (Type, Print)

Ann W. Haywood/ wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

322 Deep Shore Road Denton, Maryland 21629

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Eastern Shore Vet Cem

Date

4/19

20c. Location - City or Town, State

Hurlock, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleegle & Helfenbein Funeral Home, PA
P.O. Box 160 Greensboro, Maryland 21639

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Septic Shock

Approximate Interval Between Onset and Death

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Intra-abdominal Sepsis

2 weeks

Due to (or as a consequence of):

Pancreatic Anastomotic Leak

3 weeks

Due to (or as a consequence of):

Pancreatic Carcinoma - Whipple Procedure - 2 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Adult Respiratory Distress Syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

P11411

29d. Date signed (Month, Day, Year)

04-16-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUGO A. TORRES - 22 South Greene Street, Baltimore, MD

31. Date filed (Month, Day, Year)

APR 20 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 17671

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN WILLIAM HAMMER SR.

2. Date of Death

Month
AprilDay
23Year
1999

3. Time of Death

9:15 A.M.

4a. Facility Name (If not Institution, give street and number)

24990 Sunset Ave.

4b. City, Town, or Location of Death

Greensboro

4c. County of Death

Caroline

Funeral
Director

5. Social Security Number

217-42-5510

6. Sex

M F

7. Age (In yrs. last birthday)

60

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 24, 1939

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Greensboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

24990 Sunset Ave

10f. Zip Code

21639

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

farmer

16b. Kind of Business/Industry

grain farming

17. Father's Name (First, Middle, Last)

Charles W. Hammer

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Louise Jump Hammer

19a. Informant's Name/Relationship (Type, Print)

Mildred C. Hammer/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

24990 Sunset Ave., Greensboro, MD 21639

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Greensboro Cemetery

Date

4/26/99

20c. Location - City or Town, State

Greensboro, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleegle & Helfenbein Funeral Home, P.A.

106 W. Sunset Ave., Greensboro, MD 21639

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Non Small Cell Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

6.25 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D59887

29d. Date signed (Month, Day, Year)

4/27/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David H. Smith, M.D., 29466 Pintail Dr. Suite #5, Easton, MD 21601

31. Date filed (Month, Day, Year)

APR 27 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 17672

Reg. No.

| | | | | | | | | | |
|---|--|---|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Glasford B. Hall, Sr. | | | | 2. Date of Death
Month Day Year
April 9 1999 | | 3. Time of Death
1536 | | |
| | 4a. Facility Name (If not institution, give street and number)
The Memorial Hospital | | | | 4b. City, Town, or Location of Death
Easton | | 4c. County of Death
Talbot | | |
| Funeral
Director | 5. Social Security Number
220-26-8149 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
74 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
05/24/24 | 9. Birthplace (State or Foreign Country)
Jamaica | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD | | 10b. County
Caroline | | 10c. City, Town or Location
Federalsburg | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
204 Sullivans Mill Road | | | | 10f. Zip Code
21632 | | 10g. Citizen of What Country?
United States | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Machine Mechanic | | | 16b. Kind of Business/Industry
Plastic Prod. | | |
| 17. Father's Name (First, Middle, Last)
Ernest Hall | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Imogene Hall | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Martha J. Hall/Spouse | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
204 Sullivans Lane, Federalsburg, MD 21632 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Federal Hill Cem. | | Date
4/15 | | 20c. Location - City or Town, State
Federalsburg, MD | | | |
| 21. Signature of Funeral Service Licensee
Michael F. Eskow | | | | 22. Name and Address of Facility
Frampton-Hawkins-Eskow Funeral Home, PA
PO Box 43, Federalsburg, MD 21632 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC ADENOCARCINOMA STOMACH
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. _____
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d. _____ | | | | | | | | Approximate Interval Between Onset and Death
MONTHS | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PULMONARY HYPERTENSION | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
[Signature] | | 29c. License number
048064 | | 29d. Date signed (Month, Day, Year)
April 9, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Kevin L. Stitely, 505 Dutchman's Lane, Easton, MD 21601 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
APR 13 1999 | | 32. Registrar's Signature
[Signature] | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1945

1946

1947

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1968

1969

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17673

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Roy Hughes

2. Date of Death
Month Day Year
MAY 6 1999

3. Time of Death
12:10PM

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

162-28-2266

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

July 20 1935

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Goldsboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

P.O. Box 422

10f. Zip Code

21636

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

salesman

16b. Kind of Business/Industry

auto industry

17. Father's Name (First, Middle, Last)

William G. Hughes

18. Mother's Name (First, Middle, Maiden Surname)

Frances P. Cahall

19a. Informant's Name/Relationship (Type, Print)

Cynthia A. Hughes/ wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 422 Goldsboro, Maryland 21636

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Cremation Cn

Date

5/7

20c. Location - City or Town, State

Chester, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Fleegle & Helfenbein Funeral Home, PA
P.O. Box 160 Greensboro, MD 21639

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Cerebral Vascular Accident*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

48 hr

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Cynthia A. Hughes

29c. License number

D 52856

29d. Date signed (Month, Day, Year)

5/4/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia Rubio, MD 219 S. Washington St. Easton, MD 21601

31. Date filed (Month, Day, Year)

MAY 11 1999

32. Registrar's Signature

[Signature]

State
Registrar

HUGHES, WILLIAM

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17674

| | | | | | | | | | | |
|--|---|--|---|---|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Jennifer Melonie Justice-Yeatman | | | | 2. Date of Death
Month Day Year
APRIL 30, 1999 | | 3. Time of Death
4:00 PM. | | | |
| | 4a. Facility Name (If not institution, give street and number)
218 ACADEMY ST. | | | | 4b. City, Town, or Location of Death
FEDERALSBURG | | 4c. County of Death | | | |
| Funeral
Director | 5. Social Security Number
217-80-6276 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
29 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
06/18/69 | 9. Birthplace (State or Foreign Country)
Nebraska | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Caroline | | 10c. City, Town or Location
Federalsburg | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
218 Academy Avenue | | | | 10f. Zip Code
21632 | | 10g. Citizen of What Country?
United States | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Private Health Care | | | 16b. Kind of Business/Industry
Health Care | | | |
| | 17. Father's Name (First, Middle, Last)
Russell Souder | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Elise E. Sella Souder Hughes | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Donald E. Yeatman/Spouse | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
21632 218 Academy Avenue, Federalsburg, MD | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cambridge Crematory | | Data
5/4/99 | | 20c. Location - City or Town, State
Cambridge, Maryland | | | |
| | 21. Signature of Funeral Service Licensee
Muhaf J. Gskew | | | | 22. Name and Address of Facility
Framptom-Hawkins-Eskow Funeral Home, PA
PO Box 43, Federalsburg, MD 21632 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Intra-Oral Gunshot Wound
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
4-30-99 | | 28b. Time of Injury
205 PM | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
self-inflicted gunshot wound | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
home | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
218 Academy St. Federalsburg, MD | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and Title of certifier
Dennis J. Chute | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 01, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
MAY 5 - 1999 | | 32. Registrar's Signature
Dennis J. Chute | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17675

| | | | | | | | | | |
|--|---|---|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Griffith L. Jordan | | | | 2. Date of Death
Month Day Year
April 29, 1999 | | 3. Time of Death
02:46 | | |
| | 4a. Facility Name (If not institution, give street and number)
Johns Hopkins Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
181-10-8480 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
80 Yrs. | | 8. Date of Birth (Month, Day, Year)
Jul 12, 1918 | | |
| | 9. Birthplace (State or Foreign Country)
Phila, Pa | | 10a. State
De | | 10b. County
Kent | | 10c. City, Town or Location
Camden | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
111 Chapel Drive | | 10f. Zip Code
19934 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1943-1973 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Sergeant - USAF | | 16b. Kind of Business/Industry
Military | | | | | |
| 17. Father's Name (First, Middle, Last)
Griffith Jordan | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Helen Dougherty | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Caroline Jordan | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
111 Chapel Drive, Chapelcroft, Camden, De 19934 | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Capitol Crematory | | Date
5/2/99 | | 20c. Location - City or Town, State
Dover, Delaware | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
De. 19904 Torbert Funeral Chapel, 61 S. Bradford St, Dover, | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| e. Ventricular Fibrillation Arrest
Due to (or as a consequence of): | | | | | | | | 45 minutes | |
| b. Respiratory Failure
Due to (or as a consequence of): | | | | | | | | 3 weeks | |
| c.
Due to (or as a consequence of): | | | | | | | | | |
| d.
Due to (or as a consequence of): | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.
Ventilatory support following abdominal aortic aneurysm repair | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 MD | | 29c. License number
RES - 000 | | 29d. Date signed (Month, Day, Year)
April 29, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Risa Sargeant 600 North Wolfe Street Baltimore, Maryland 21287 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 4 - 1999 | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

99 17676

DHHM 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 17677

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **William Eugene LEADER** 2. Date of Death Month **APRIL** Day **8** Year **1999** 3. Time of Death **10:55 AM**

4a. Facility Name (If not Institution, give street and number) **SHORE NURSING & REHABILITATION CTR.** 4b. City, Town, or Location of Death **DENTON** 4c. County of Death **CAROLINE**

Funeral
Director

5. Social Security Number **221-03-1263** 6. Sex **1** M **2** F 7. Age (In yrs. last birthday) **94** Yrs. 8. Date of Birth (Month, Day, Year) **September 22, 1904** 9. Birthplace (State or Foreign Country) **New York**

Usual Residence of Decedent

10a. State **Maryland** 10b. County **Caroline** 10c. City, Town or Location **Denton** 10d. Inside City Limits **1** Yes **2** No

10e. Street and Number **410 Colonial Drive** 10f. Zip Code **21629** 10g. Citizen of What Country? **United States**

11. Marital Status **1** Never Married **2** Married **3** Widowed **4** Divorced 12. Was Decedent Ever in U.S. Armed Forces? **1** Yes **2** No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) **1** Yes **2** No Specify: 14. Race - American Indian, Black, White, etc. Specify: **Caucasian**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **12** College (14 or 5+) **4** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Federal Tax Accountant** 16b. Kind of Business/Industry **Manufacturing Company**

17. Father's Name (First, Middle, Last) **William Leader** 18. Mother's Name (First, Middle, Maiden Surname) **Elizabeth Barnett**

19a. Informant's Name/Relationship (Type, Print) **Richard C. Leader** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **150 Knoll Wood Road, Elkton, Maryland 21921**

20a. Method of Disposition **1** Burial **2** ☒ Cremation **3** Removal from State **4** Donation **5** Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Capitol Crematory** Date **4/9/99** 20c. Location - City or Town, State **Dover, Delaware**

21. Signature of Funeral Service Licensee *Charles Moore* 22. Name and Address of Facility **Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. **Sepsis** Due to (or as a consequence of): **24 hours**
b. **urinary tract infection** Due to (or as a consequence of): **3 days**
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BPH, Atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 Yes **2** No **3** Probably **4** Unknown

24a. Was an autopsy performed?

1 Yes **2** No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes **2** No25. Was case referred to medical examiner? **1** Yes **2** No26. Place of Death (Check only one) Hospital: **1** Inpatient **2** ER/Outpatient **3** DOA Other: **4** Nursing Home **5** Residence **8** Other (Specify)27. Manner of Death **1** Natural **5** Pending investigation **2** Accident **6** Could not be determined **3** Suicide **4** Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury **M**28c. Injury at work? **1** Yes **2** No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **2** ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.29b. Signature and title of certifier *[Signature]* MD29c. License number **00053255**29d. Date signed (Month, Day, Year) **4/8/99**30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **Melinda Butler, M.D.****609 Daffin Lane PO Box 660 Denton MD 21629**

31. Date filed (Month, Day, Year)

APR 09 1999Registrar's Signature *[Signature]*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17678

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Carman Leggett

2. Date of Death

Month
04Day
12Year
1999

3. Time of Death

06:30 P.M.

4a. Facility Name (If not institution, give street end number)

Caroline Nursing Home, Inc.

4b. City, Town, or Location of Death

Denton, Maryland

4c. County of Death

Caroline

Funeral
Director

5. Social Security Number

130-14-3891

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 1 1911

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10e. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Greensboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12945 Greensboro Road

10f. Zip Code

21639

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Navar Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 42-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Senior Examiner

16b. Kind of Business/Industry

State of Maryland

17. Father's Name (First, Middle, Last)

William Carman Leggett

18. Mother's Name (First, Middle, Maiden Summa)

Achsa Taylor Leggett

19a. Informant's Name/Relationship (Type, Print)

Roberta J. Leggett/ wife

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

12945 Greensboro Road Greensboro, MD 21639

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greensboro Cemetery

Date

4/16

20c. Location - City or Town, State

Greensboro, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleegle & Helfenbein Funeral Home, PA
P.O. Box 160 Greensboro, MD 21639

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 31376

29d. Date signed (Month, Day, Year)

4-12-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Sides 920 Market St Denton MD 21629

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Robert MacDonald | | | | | | 2. DATE OF DEATH
MONTH DAY YEAR
April 23 1999 | | | | 3. TIME OF DEATH
4:25 AM | | | | | |
| 4. SOCIAL SECURITY NUMBER
218-42-4084 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
62 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year)
December 26, 1936 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
27646 Liden School Road | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Federalsburg | | | | 9c. COUNTY OF DEATH
Caroline | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Caroline | | 10c. CITY, TOWN OR LOCATION
Federalsburg | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
27646 Liden School Road | | | | | | 10f. ZIP CODE
21632 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | | | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Caucasian | | | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
11 HS Grad. | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Farmer | | | | 16b. KIND OF BUSINESS/INDUSTRY
Farming | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John MacDonald | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Evelyn Torbert | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Olga H. MacDonald | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
27646 Liden School Road, Federalsburg, Maryland 21632 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Denton Cemetery | | DATE
4/27 | | 20c. LOCATION — City or Town, State
Denton, Maryland | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Randolph P. Moore</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY
Moore Funeral Home, P.A. 21629
12 South Second Street, Denton, Maryland | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic breast carcinoma
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | Approximate interval Between Onset and Death
2 months | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Undetermined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>David H. Smith</i> | | | | | | 29c. LICENSE NUMBER
D39817 | | 29d. DATE SIGNED (Month, Day, Year)
5/13/99 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
David H. Smith, M.D., 509 Idlewild Avenue, Easton, Maryland 21601 | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 4 - 1999 | | | | 32. REGISTRAR'S SIGNATURE
<i>J. Sparks</i> | | | | | | | | | | | |

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17680

| | | | | | | | | |
|---|---|---|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ALBERT E. MAKOSKI | | | | 2. Date of Death
Month MAY Day 19 Year 1999 | | 3. Time of Death
6:12 am | |
| | 4a. Facility Name (If not institution, give street and number)
WILLIAM HILL MANOR | | | | 4b. City, Town, or Location of Death
EASTON | | 4c. County of Death
TALBOT | |
| Funeral
Director | 5. Social Security Number
214-01-4063 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
94 Yrs. | | 8. Date of Birth (Month, Day, Year)
November 23, 1904 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10. Usual Residence of Decedent
10a. State Maryland 10b. County Talbot 10c. City, Town or Location Easton | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number
501 Dutchman's Lane Apt. 112 | | 10f. Zip Code
21601 | | 10g. Citizen of What Country?
United States | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Caucasian | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Manufacturer | | 16b. Kind of Business/Industry
Exon U.S.A. | | | | |
| 17. Father's Name (First, Middle, Last)
Herman Otto Makoski | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Ordunns Ordnung | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Paul Makosky Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7223 Drum Point Road, St. Michaels, Maryland 21663 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Capitol Crematory | | 20c. Location - City or Town, State
5/20 Dover, Delaware | | | | |
| 21. Signature of Funeral Service Licensee
Randolph P. Moore | | | | 22. Name and Address of Facility
Harrison E. Leonard Funeral Home
PO Box 477, St. Michaels, Maryland 21663 | | | | |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
PROSTATE CANCER
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
YEARS | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSIVE CARDIOVASCULAR DISEASE | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
W. Bremer MD | | 29c. License number
D26350 | | 29d. Date signed (Month, Day, Year)
5/19/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William S. Bremer, M.D., 800 South Talbot Street, St. Michaels, Maryland 21663 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 20 1999 | | 32. Registrar's Signature
Anna B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

State
Registrar

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|--|---|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
William Desmond Marvel | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 20, 1999 | | 3. TIME OF DEATH
1:00 AM | | | | |
| 4. SOCIAL SECURITY NUMBER
547-38-8479 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
July 18, 1928 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | | |
| 9a. FACILITY NAME (If not institution, give street and number)
3015 South Kent Narrow Way | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Grasonville | | | | 9c. COUNTY OF DEATH
Queen Anne's | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Caroline | | 10c. CITY, TOWN OR LOCATION
Ridgely | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER
238 Oakland Road | | | | 10f. ZIP CODE
21660 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Caucasian | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Owner and Operator | | | | 16b. KIND OF BUSINESS/INDUSTRY
Beverage Manufacturing | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
William Desmond Marvel, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Fannie Saunders | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Phyllis L. Marvel | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PO Box 401, Ridgely, Maryland 21660 | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Denton Cemetery | | DATE
5/24 | | 20c. LOCATION — City or Town, State
Denton, Maryland | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Randolph P. Moore | | | | 22. NAME AND ADDRESS OF FACILITY
Moore Funeral Home, P.A. 21629
12 South Second Street, Denton, Maryland | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Myocardial Infarction
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
a. DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.
Approximate Interval Between Onset and Death
1 day | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Euphysema | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Dr. J. Spence | | | | 29c. LICENSE NUMBER
D32136 | | 29d. DATE SIGNED (Month, Day, Year)
5/21/99 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Gas J. Spence 2108 D. Dumb Drive Choke, MD 21619 | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 24 1999 | | 32. REGISTRAR'S SIGNATURE
B. Sparks | | | | | | | | |

THE END OF THE LINE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17682

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MYERS EDWIN NAGEL

2. Date of Death

Month Day Year
MAY 21, 1999

3. Time of Death

1000

Funeral
Director

4e. Facility Name (If not institution, give street and number)

4490 Laurel Grove Road

4b. City, Town, or Location of Death

Federalsburg

4c. County of Death

Caroline

5. Social Security Number

220-34-9568

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 21 '31

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Caroline

10c. City, Town or Location

Federalsburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4490 Laurel Grove Road

10f. Zip Code

21632

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Poultry & Grain Farmer

16b. Kind of Business/Industry

Poultry/
Agriculture

17. Father's Name (First, Middle, Last)

Christian Nagel

18. Mother's Name (First, Middle, Maiden Surname)

Minnie McMahan

19a. Informant's Name/Relationship (Type, Print)

JoAnne Y. Nagel/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21632
4490 Laurel Grove Road, Federalsburg, MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Hill Crest Cemetery

Date

5/24

20c. Location - City or Town, State

Federalsburg, MD

21. Signature of Funeral Service Licensee

Michael F. Eskow

22. Name and Address of Facility

Frampton-Hawkins-Eskow Funeral Home, PA
PO Box 43, Federalsburg, MD 2163223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Chronic Obstructive Pulmonary disease years

Due to (or as a consequence of):

b. Congestive heart failure years

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accidental 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael F. Eskow

29c. License number

H47357

29d. Date signed (Month, Day, Year)

5-21-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

321 Bloomingdale Ave, Federalsburg, mo 21632, Anne L. Gentry

31. Date filed (Month, Day, Year)

MAY 24 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17683

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nelson E. Pinkine

2. Date of Death

Month
AprilDay
2Year
1999

3. Time of Death

PM

4a. Facility Name (If not institution, give street and number)

13 W. First Street

4b. City, Town, or Location of Death

Ridgely

4c. County of Death

Caroline

Funeral
Director

5. Social Security Number

215-36-1169

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

58

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
July 10 1940

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Ridgely

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

13 W. First Street

10f. Zip Code

21660

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

owner/operator

16b. Kind of Business/Industry

retail grocery store

17. Father's Name (First, Middle, Last)

Edward M. Pinkine

18. Mother's Name (First, Middle, Maiden Surname)

Ruth V. Hicks Pinkine

19a. Informant's Name/Relationship (Type, Print)

Diane M. West/ sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

31257 Dukes Bridge Road Cordova 21625

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Greensboro Cemetery

Date

4/11

20c. Location - City or Town, State

Greensboro, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleegle & Helfenbein Funeral Home, PA
P.O. Box 160 Greensboro, MD 2163923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. HYPERTENSIVE CARDIOVASCULAR DISEASE CHRONIC

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

ACUTE

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation
6 ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

M.E. D14664

29d. Date signed (Month, Day, Year)

4/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHRISTIAN E. JENSEN MD, PO Box 690, PENTON MD 21629

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 17684

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|--|---|--|--|---|--|--|--|--|---|----|-----------|--|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|--|--|----|--|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|--|--|----|--|--|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|--|--|--|----|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Mabel Catherine Rich | | | | | | 2. Date of Death
Month 04 Day 20 Year 99 | | 3. Time of Death
5:25AM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not Institution, give street and number)
CAROLINE NURSING HOME, INC | | | | | | 4b. City, Town, or Location of Death
DENTON, MD | | 4c. County of Death
CAROLINE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
215-01-0123 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
90 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct 05 1908 | | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Caroline | | 10c. City, Town or Location
Denton | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 10e. Street and Number
520 Kerr Ave. | | | | 10f. Zip Code
21629 | | 10g. Citizen of What Country?
U.S.A. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 02 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
medical assistant | | | 16b. Kind of Business/Industry
family physician | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Charles Rich | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Annie Gibson Rich | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Carole Marder/ trustee | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mail Stop 101-621 25 S. Charles St. Balt. MD 21201 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greensboro Cemetery | | Date
4/24 | | 20c. Location - City or Town, State
Greensboro, MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Fleegle & Helfenbein Funeral Home, P.A.
P.O. Box 160 Greensboro, MD 21639 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td colspan="8">Pneumonia</td> <td rowspan="4">Approximate Interval Between Onset and Death
days</td> </tr> <tr> <td colspan="10">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td colspan="8"></td> </tr> <tr> <td colspan="10">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td colspan="8"></td> <td></td> </tr> <tr> <td colspan="10">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td colspan="8"></td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | Pneumonia | | | | | | | | Approximate Interval Between Onset and Death
days | Due to (or as a consequence of): | | | | | | | | | | b. | | | | | | | | | Due to (or as a consequence of): | | | | | | | | | | c. | | | | | | | | | | Due to (or as a consequence of): | | | | | | | | | | | d. | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | Pneumonia | | | | | | | | Approximate Interval Between Onset and Death
days | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | b. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Alzheimer's dementia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 29b. Signature and title of certifier
M.D. | | | | 29c. License number
D47534 | | | 29d. Date signed (Month, Day, Year)
4/20/99 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
WAGIE IZOR, M.D. 920 Market St Denton MD 21629 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | State Registrar | 31. Date filed (Month, Day, Year)
APR 22 1999 | | | | 32. Registrar's Signature
 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17685

| | | | | | | | | | |
|--|--|---|--|---|---|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Edward Ross Robinson | | | | 2. Date of Death
Month May Day 27 Year 1999 | | 3. Time of Death
1:45pm | | |
| | 4a. Facility Name (If not Institution, give street and number)
The Memorial Hospital | | | | 4b. City, Town, or Location of Death
Easton | | 4c. County of Death
Talbot | | |
| Funeral
Director | 5. Social Security Number
219-07-3882 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
83 Yrs. | | 8. Date of Birth (Month, Day, Year)
Jan. 22, 1916 | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Caroline | | 10c. City, Town or Location
Federalsburg | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
4950 Long Swamp Road | | 10f. Zip Code
21632 | | 10g. Citizen of What Country?
United States | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Farmer | | 16b. Kind of Business/Industry
Dairy | | | | | |
| 17. Father's Name (First, Middle, Last)
William John Robinson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Catherine Ross Robinson | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
William H. Robinson/nephew | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4901 Long Swamp RD, Federalsburg, MD 21632 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hill Crest Cemetery | | Date
5/30 | | 20c. Location - City or Town, State
Federalsburg, MD | | | |
| 21. Signature of Funeral Service Licensee
Michael F. Eskow | | | | 22. Name and Address of Facility
Frampton-Hawkins-Eskow Funeral Home, PA
P.O. Box 43, Federalsburg, MD 21632 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION 1°
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Andrea Allen MD | | 29c. License number
D35284 | | 29d. Date signed (Month, Day, Year)
5/27/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. Andrea Allen 219 South Washington Street, Easton, Maryland 21601 | | | | 31. Date filed (Month, Day, Year)
MAY 28 1999 | | | | 32. Registrar's Signature
B. Sparks | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Kenneth William Reed | | | | 2. DATE OF DEATH
MONTH DAY YEAR
May 18 1999 | | 3. TIME OF DEATH
2 P M | |
| 4. SOCIAL SECURITY NUMBER
213-22-9180 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)
69 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
July 5, 1929 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number)
25404 Smith Landing Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Denton | | 9c. COUNTY OF DEATH
Caroline | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Caroline | | 10c. CITY, TOWN OR LOCATION
Denton | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
25404 Smith Landing Road | | | |
| 10f. ZIP CODE
21629 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES 1952-1954 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Equipment Operator | | 16b. KIND OF BUSINESS/INDUSTRY
County Roads | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John Amos Reed | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Elva Elizabeth Jones | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Don Reed, Sr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Son 522 North Sixth Street, Denton, Maryland 21629 | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Maryland Eastern Shore Veterans' Cemetery 5/24 | | 20c. LOCATION — City or Town, State
Beulah, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Randolph P. Moore</i> | | 22. NAME AND ADDRESS OF FACILITY
Moore Funeral Home, P.A. 21629
12 South Second Street, Denton, Maryland | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) →
ACUTE MYOCARDIAL INFARCTION
DUE TO (OR AS A CONSEQUENCE OF):
HYPERTENSIVE CARDIOVASCULAR DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
CHRONIC | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPERLIPIDEMIA | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Christian E. Jensen MD Deputy</i> | | 29c. LICENSE NUMBER
ME D14664 | | 29d. DATE SIGNED (Month, Day, Year)
5/21/99 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Christian E. Jensen, M.D., PO Box 690, Denton, Maryland 21629 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
MAY 24 1999 | | 32. REGISTRAR'S SIGNATURE
<i>B. Sparks</i> | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | CERTIFICATE OF DEATH | | REG. NO. | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Howard Sharp | | | | 2. DATE OF DEATH
MONTH DAY YEAR
April 28, 1999 | | 3. TIME OF DEATH
2 A M | |
| 4. SOCIAL SECURITY NUMBER
213-14-1132 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
August 30, 1913 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | 9a. FACILITY NAME (If not institution, give street and number)
8187 Harmony Road | | 9b. CITY, TOWN OR LOCATION OF DEATH
Denton | | 9c. COUNTY OF DEATH
Caroline | |
| 10a. STATE
Maryland | | 10b. COUNTY
Caroline | | 10c. CITY, TOWN OR LOCATION
Denton | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
8187 Harmony Road | | 10f. ZIP CODE
21629 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 1942-1945
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8
College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Farmer and Carpenter | | 16b. KIND OF BUSINESS/INDUSTRY
Farming and Construction | | | |
| 17. FATHER'S NAME (First, Middle, Last)
John Byard Sharp | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Anna Davis Stewart | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Robert Gibson Sharp Brother | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
24659 Williston Road, Denton, Maryland 21629 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Holy Cross Cemetery | | DATE
5/1 | | 20c. LOCATION — City or Town, State
near Denton, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Robert P. Moore</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Moore Funeral Home, P.A.
12 South Second Street, Denton, MD 21629 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE MYOCARDIAL INFARCTION
DUE TO (OR AS A CONSEQUENCE OF):
ISCHEMIC CARDIOVASCULAR DISEASE
DUE TO (OR AS A CONSEQUENCE OF):

Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DIABETES MELLITUS
HYPERLIPIDEMIA
RENAL INSUFFICIENCY

Approximate Interval Between Onset and Death
ACUTE
CHRONIC | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS
HYPERLIPIDEMIA
RENAL INSUFFICIENCY | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO
N/A | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Christian E. Jensen MD</i> | | | | 29c. LICENSE NUMBER
D14664 | | 29d. DATE SIGNED (Month, Day, Year)
4/29/99 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Christian E. Jensen, PO Box 690, Denton, Maryland 21629 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
APR 30 1999 | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17688

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

J. LEONARD SCHEVEL

2. Date of Death

April

Day

10

Year

1999

3. Time of Death

1300

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

218-20-2520

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

01/29/23

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Caroline

10c. City, Town or Location

Federalsburg

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4964 Preston Road

10f. Zip Code

21632

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates: '45-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Auto Mechanic

16b. Kind of Business/Industry

Car Dealership

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Marie Schevel

19a. Informant's Name/Relationship (Type, Print)

Mrs. Betty N. Schevel/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4964 Preston Road, Federalsburg, MD 21632

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hill Crest Cemetery

Data

4/14

20c. Location - City or Town, State

Federalsburg, MD

21. Signature of Funeral Service Licensee

Michael F. Eskow

22. Name and Address of Facility

Frampton-Hawkins-Eskow Funeral Home, PA
PO Box 43, Federalsburg, MD 21632

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

b. PNEUMONIA

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

3 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael F. Eskow, M.D.

29c. License number

D29168

29d. Date signed (Month, Day, Year)

4/10/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ROBERT B. ALLEN, MD, 100 POWER STREET, SALISBURY, MD 21804

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17689

| | | | | | | | | |
|--|--|---|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Lena Elizabeth States | | | | 2. Date of Death
Month Day Year
May 10 1999 | | 3. Time of Death
1:00 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Genesis ElderCare - The Pines | | | | 4b. City, Town, or Location of Death
Easton | | 4c. County of Death
Talbot | |
| Funeral
Director | 5. Social Security Number
215-18-4462 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
76 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
07/24/22 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
Caroline | | 10c. City, Town or Location
Denton | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
902 A Gay Street | | | | 10f. Zip Code
21629 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | |
| 17. Father's Name (First, Middle, Last)
Phillip E. Hopkins | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sadie E. Williamson | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Barbara Brock/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1308 Riley Rd., New Castle, IN 47362 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Junior Order | | Date
5/13/99 | | 20c. Location - City or Town, State
Preston, Maryland |
| 21. Signature of Funeral Service Licensee
Muhad J. Gabun | | | | 22. Name and Address of Facility
Frampton-Hawkins-Eskow Funeral Home, PA | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Congestive heart failure
Due to (or as a consequence of):
b. Atherosclerosis, generalized
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d. | | | | | | | | Approximate Interval Between Onset and Death
hours
years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Pancreatic carcinoma, metastatic
Forearm rock fracture, left; recent | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
MD Medical Director | | 29c. License number
025933 | | 29d. Date signed (Month, Day, Year)
5.11.99 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MICHAEL CROWLEY MD 508 IDLEWILD AVENUE EASTON, MD 21601 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 12 1999 | | | | 32. Registrar's Signature
B. Sparks | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17690

| | | | | | | | | |
|---|---|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ROBERT SCOTT | | | | 2. Date of Death
Month May Day 16 Year 1999 | | 3. Time of Death
0322 Am | |
| | 4a. Facility Name (If not institution, give street and number)
Dorchester General Hospital | | | | 4b. City, Town, or Location of Death
Cambridge | | 4c. County of Death
Dorchester | |
| Funeral
Director | 5. Social Security Number
220-12-1094 | | 6. Sex
1 M 2 F | | 7. Age (In yrs. last birthday)
97 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 10, 1902 | |
| | 9. Birthplace (State or Foreign Country)
S. Carolina | | 10a. State
MD | | 10b. County
Dorchester | | 10c. City, Town or Location
Cambridge | |
| To Be Completed by Funeral Director | Usual Residence of Decedent
10e. Street and Number
520 Glenburn Avenue | | | | 10f. Zip Code
21613 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Farmer | | 16b. Kind of Business/Industry
Agriculture | |
| | 17. Father's Name (First, Middle, Last)
Unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Margaret Elbert/Niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
301 Nealson St., Hurlock, MD 21643 | | | |
| | 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Thompsons town Cem. | | 20c. Date
5/19/99 | | 20d. Location - City or Town, State
Hurlock, Maryland | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
Michael J. Ekm | | | | 22. Name and Address of Facility
Frampton-Hawkins-Eskow Funeral Home, PA
PO Box 43, Federalsburg, MD 21632 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Septic Shock
Due to (or as a consequence of):
b. Aspiration pneumonia
Due to (or as a consequence of):
c. Severe Electrolyte abnormality
Due to (or as a consequence of):
d. Status post CVA | | | | Approximate Interval Between Onset and Death
days
days
days
years | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
B/c Above the Knee Amputation | | | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | | | |
| | 24a. Was an autopsy performed?
1 Yes 2 No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 Yes 2 No | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| | 27. Manner of Death
1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
Michael J. Ekm | | | |
| To Be Completed by Physician/Medical Examiner | 29c. License number
D50987 | | | | 29d. Date signed (Month, Day, Year)
5/16/99 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ahmed Nawaz 105 Aurora street Cambridge MD 21613 | | | | 31. Date filed (Month, Day, Year)
MAY 19 1999 | | | |
| State Registrar | 32. Registrar's Signature
B. Sparks | | | | 33. Date of Death
MD 21613 | | | |

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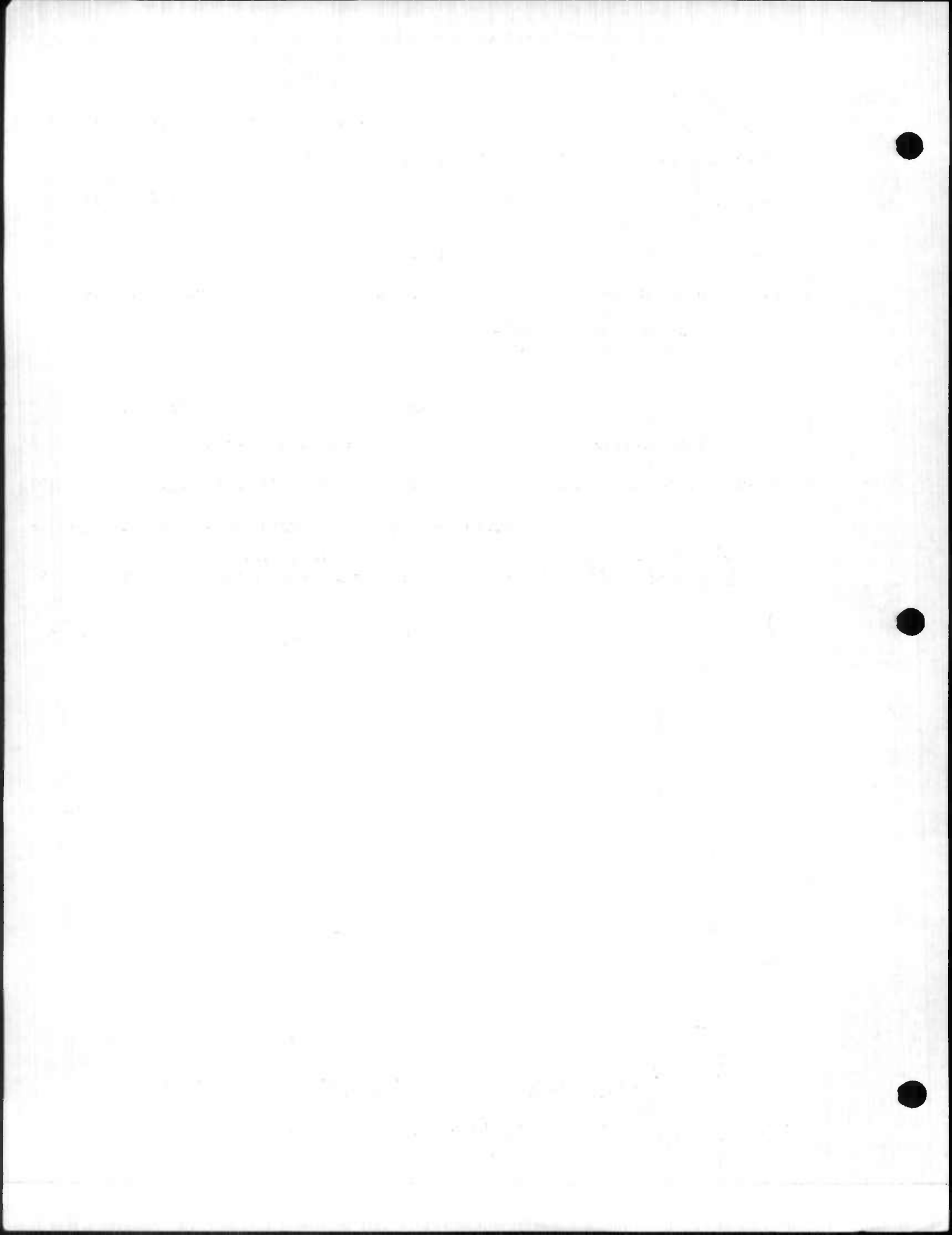
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99 17691

| Physician /Medical Examiner | | Decedent's Name (First, Middle, Last) | | Date of Death | | Day | | Year | | Time of Death | |
|-----------------------------|--|--|--|--|--|--|--|--|--|------------------------------|--|
| | | WILMER LEE TRICE | | APRIL 7 1999 | | 11:42 PM | | | | | |
| Funeral Director | | Facility Name (If not institution, give street and number) | | City, Town, or Location of Death | | County of Death | | | | | |
| | | SHORE NURSING & REHABILITATION CTR. | | DENTON | | CAROLINE | | | | | |
| | | Social Security Number | | Sex | | Age (In yrs. last birthday) | | If Under 1 Year | | If Under 24 Hrs. | |
| | | 219-28-8820 | | 1 M 2 F | | 66 Yrs. | | Months Days | | Hours Min. | |
| | | Usual Residence of Decedent | | State | | County | | City, Town or Location | | Inside City Limits | |
| | | Maryland Caroline | | Federalburg | | | | | | 1 Yes 2 No | |
| | | Street and Number | | Zip Code | | Citizen of What Country? | | | | | |
| | | 101 Fair Haven Manor | | 21632 | | United States | | | | | |
| | | Marital Status | | Was Decedent Ever in U.S. Armed Forces? | | Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | | Race - American Indian, Black, White, etc. | | Specify: | |
| | | 1 Never Married 2 Married
3 Widowed 4 Divorced | | 1 Yes 2 No 1950-
If Yes, Give Year or Dates: 1950 | | 1 Yes 2 No Specify: | | Caucasian | | | |
| | | Decedent's Education (Specify only highest grade completed) | | Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | Kind of Business/Industry | | | | | |
| | | Elementary/Secondary (0-12) College (1-4or 5+)
8 | | Farmer | | Farming | | | | | |
| | | Father's Name (First, Middle, Last) | | Mother's Name (First, Middle, Maiden Surname) | | | | | | | |
| | | Roland Linwood Trice | | Elma Geneva Moore | | | | | | | |
| | | Informant's Name/Relationship (Type, Print) | | Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | |
| | | Mildred S. Trice Wife | | 101 Fair Haven Manor, Federalburg, Maryland 21632 | | | | | | | |
| | | Method of Disposition | | Place of Disposition (Name of cemetery, crematory or other place) | | Date | | Location - City or Town, State | | | |
| | | 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | Concord Cemetery | | 4/10/99 | | near Denton, Maryland | | | |
| | | Signature of Funeral Service Licensee | | Name and Address of Facility | | | | | | | |
| | | Charles E. Moore | | Moore Funeral Home, P.A.
12 South Second Street, Denton, Maryland 21629 | | | | | | | |
| | | Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | Approximate Interval Between Onset and Death | | | | | | | |
| | | Immediate Cause (Final disease or condition resulting in death) | | Cerebral Hemorrhage | | 2 wks | | | | | |
| | | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | Due to (or as a consequence of): | | | | | | | |
| | | { | | Due to (or as a consequence of): | | | | | | | |
| | | | | Due to (or as a consequence of): | | | | | | | |
| | | | | Due to (or as a consequence of): | | | | | | | |
| | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | Did tobacco use contribute to the cause of death? | | 1 Yes 2 No 3 Probably 4 Unknown | | | | | |
| | | | | Was an autopsy performed? | | Were autopsy findings available prior to completion of cause of death? | | 1 Yes 2 No 1 Yes 2 No | | | |
| | | Was case referred to medical examiner?
1 Yes 2 No | | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) | | | | | | | |
| | | Manner of Death | | Date of Injury (Month, Day, Year) | | Time of Injury | | Injury at Work? 1 Yes 2 No | | Describe how injury occurred | |
| | | 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | | Certifier (Check only one) | | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| | | Signature and title of certifier | | License number | | Date signed (Month, Day, Year) | | | | | |
| | | G. J. Spruse | | D32306 | | 4/9/99 | | | | | |
| | | Name and address of person who completed cause of death (item 23e) (Type, Print) | | | | | | | | | |
| | | G. J. Spruse 2107 N. Davis Drive Clark, MO 21619 | | | | | | | | | |
| | | Date filed (Month, Day, Year) | | Registrar's Signature | | | | | | | |
| | | APR 09 1999 | | B. B. Spruce | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17692

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LOUISE W. TULL

2. Date of Death

4 11 99

3. Time of Death
6:50 AM

4a. Facility Name (If not institution, give street and number)

27309 Willin Lane

4b. City, Town, or Location of Death

Federalsburg

4c. County of Death

Caroline

Funeral
Director

5. Social Security Number

215-03-2583

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 26, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Caroline

10c. City, Town or Location

Federalsburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

27309 Willin Lane

10f. Zip Code

21632

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7th

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Sales Associate

16b. Kind of Business/Industry

Retail Clothing

17. Father's Name (First, Middle, Last)

Martin Wheatley

18. Mother's Name (First, Middle, Maiden Surname)

Maggie Riggin Wheatley

19a. Informant's Name/Relationship (Type, Print)

Richard Tull, Sr./Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

27309 Willin Lane, Federalsburg, MD 21632

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Hill Crest Cemetery

Date

4/14

20c. Location - City or Town, State

Federalsburg, MD

21. Signature of Funeral Service Licensee

Michael J. Eskow

22. Name and Address of Facility

Frampton-Hawkins-Eskow Funeral Home
P.O. Box 43 Federalsburg, MD 2163223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

ACUTE

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

R. Jensen MD Deputy ME. DI4664

29c. License number

29d. Date signed (Month, Day, Year)

4/11/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PO Box 690, DENTON MD 21629

31. Date filed (Month, Day, Year)

APR 14 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17693

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
DAVID LESLIE TOWNSEND, Sr. | | | | 2. Date of Death
Month, Day, Year
April 21, 1999 | | 3. Time of Death
1355 | |
| 4a. Facility Name (If not institution, give street and number)
University of Maryland Medical Center | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore | |
| 5. Social Security Number
555-60-1193 | | 6. Sex
1 M 2 F | | 7. Age (In yrs. last birthday)
56 Yrs. | | 8. Date of Birth (Month, Day, Year)
September 10, 1942 | |
| 9. Birthplace (State or Foreign Country)
Pennsylvania | | 10a. State
Maryland | | 10b. County
Caroline | | 10c. City, Town or Location
Denton | |
| 10d. Inside City Limits
1 Yes 2 No | | 10e. Street and Number
10 South Ninth Street | | 10f. Zip Code
21629 | | 10g. Citizen of What Country?
United States | |
| 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: 1959-1967 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Caucasian | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
12 HS Grad. | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Truck Driver | | 16b. Kind of Business/Industry
Trucking | | 17. Father's Name (First, Middle, Last)
Wilbur Lewis Townsend | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Ruth Mildred Frost | | 19a. Informant's Name/Relationship (Type, Print)
Teresa L. Townsend Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10 South Ninth Street, Denton, Maryland 21629 | | 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Eastern Shore Veterans | | 20c. Date
4/26 | | 20d. Location - City or Town, State
Bethesda, Maryland | | 21. Signature of Funeral Service Licensee
[Signature] | |
| 22. Name and Address of Facility
Moore Funeral Home, P.A.
12 South Second Street, Denton, Maryland 21629 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. MITRAL VALVE DISEASE
Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE
Due to (or as a consequence of):
c. DIABETES MELLITUS
Due to (or as a consequence of):
d. HEART FAILURE | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | | 23c. Was an autopsy performed?
1 Yes 2 No | |
| 23d. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | | 24. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KURT WEHBERG, M.D. RESIDENT, 22 SOUTH GREEVE STREET, BALTIMORE, MD 21201 | | 25. Was case referred to medical examiner?
1 Yes 2 No | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | |
| 27. Manner of Death
1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year)
M | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. Signature and title of certifier
[Signature] RESIDENT | | 29c. License number
D46536 | | 29d. Date signed (Month, Day, Year)
5/17/99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KURT WEHBERG, M.D. RESIDENT, 22 SOUTH GREEVE STREET, BALTIMORE, MD 21201 | |
| 31. Date filed (Month, Day, Year)
MAY 20 1999 | | 32. Registrar's Signature
[Signature] | | 33. State Registrar | | 34. State Registrar | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17694

| | | | | | | | | |
|--|--|---|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Lillian Matilda Willey | | | | 2. Date of Death
Month 04 Day 23 Year 99 | | 3. Time of Death
8:20AM | |
| | 4a. Facility Name (If not institution, give street and number)
CAROLINE NURSING HOME, INC. | | | | 4b. City, Town, or Location of Death
DENTON | | 4c. County of Death
CAROLINE | |
| Funeral
Director | 5. Social Security Number
216-18-8641 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
94 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
October 5, 1904 | 9. Birthplace (State or Foreign Country)
Delaware |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Caroline | 10c. City, Town or Location
Ridgely | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
306 Park Avenue | | | 10f. Zip Code
21660 | | 10g. Citizen of What Country?
United States | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify:
Caucasian | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Home | |
| | 17. Father's Name (First, Middle, Last)
Unknown Read | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Emily Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Etta Redden Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PO Box 144, Ridgely, Maryland 21660 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Denton Cemetery | | Date
4/27/99 | 20c. Location - City or Town, State
Denton, Maryland | | |
| | 21. Signature of Funeral Service Licensee
<i>Randolph P. Moore</i> | | | | 22. Name and Address of Facility
Moore Funeral Home, P.A.
12 South Second Street, Denton, Maryland 21629 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b. Aspiration
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Alzheimer's Disease - end stage | | | | | | | Approximate Interval Between Onset and Death
4 days
3 months |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Alzheimer's Disease - end stage | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
<i>Karen Moffett</i> | | 29c. License number
151639 | | 29d. Date signed (Month, Day, Year)
4-23-99 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KAREN MOFFETT CHOPTANK COMMUNITY HEALTH SYSTEMS P.O. BOX 660 DENTON, MD 21629 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
APR 27 1999 | | 32. Registrar's Signature
<i>B. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17695

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Johnnie A. Wright

2. Date of Death

May 1

Day

1999

Year

3. Time of Death

1214

4a. Facility Name (If not Institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

221-26-4269

6. Sex

XXM 2□ F

7. Age (In yrs. last birthday)

62

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec 1, 1936

9. Birthplace (State or Foreign Country)

Dover, De

Usual Residence of Decedent

10a. State

De

10b. County

Kent

10c. City, Town or Location

Dover

10d. Inside City Limits

1□ Yes 2□ No

10e. Street and Number

4526 Kenton Rd.

10f. Zip Code

19904

10g. Citizen of What Country?

USA

11. Marital Status

1□ Navar Married 2~~X~~ Married
3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S.

1~~X~~ Yes 2□ No
If Yes, Give Year or Dates: 1954-1957

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2~~X~~ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

truck & bus driver

16b. Kind of Business/Industry

Electric supply

17. Father's Name (First, Middle, Last)

James N. Wright

18. Mother's Name (First, Middle, Maiden Surname)

Madeline Moore

19a. Informant's Name/Relationship (Type, Print)

Loretta Wright

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4526 Kenton Rd, Dover, De 19904

20a. Method of Disposition

1~~X~~ Burial 2□ Cremation 3□ Removal from State
4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sharon Hills Mem Park

Date

5/5/99

20c. Location - City or Town, State

Dover, Delaware

21. Signature of Funeral Service Licensee

William Corbett Torbert

22. Name and Address of Facility

Torbert Funeral Chapel, 61 S Bradford St, Dover, De 19904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ASCVD

a.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 yrs

b.

Due to (or as a consequence of):

20 yrs

c.

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1~~X~~ Yes 2□ No 3□ Probably 4□ Unknown

24a. Was an autopsy performed?

1□ Yes 2~~X~~ No

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2~~X~~ No

25. Was case referred to medical examiner?

1~~X~~ Yes 2□ No

26. Place of Death (Check only one)

Hospital:

1□ Inpatient

2~~X~~ ER/Outpatient

3□ DOA

Other:

4□ Nursing Home

5□ Residence

6□ Other (Specify)

27. Manner of Death

1~~X~~ Natural 5□ Pending investigation
2□ Accident 6□ Could not be determined
3□ Suicide 4□ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1□ Yes 2□ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1□ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2~~X~~ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Chun S. DME

29c. License number

H50497

29d. Date signed (Month, Day, Year)

5/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

108 Pine Bluff Rd. Salisbury MD 21801

31. Date filed (Month, Day, Year)

MAY 4 - 1999

32. Registrar's Signature

B. Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

221-26-4269

Johnny A. Wright

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 17696

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|---------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last)
RUSSELL JOSEPH WALDIS | | 2. Date of Death
Month MAY Day 1 Year 1999 | | 3. Time of Death
2:12 PM | |
| 4a. Facility Name (If not institution, give street and number)
Shore Nursing & Rehab. Center | | 4b. City, Town, or Location of Death
Denton | | 4c. County of Death
Caroline | |
| 5. Social Security Number
216-12-1072 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
87 Yrs. | If Under 1 Year
Months | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Apr. 20, 1912 |
| 9. Birthplace (State or Foreign Country)
Maryland | | Usual Residence of Decedent | | | |
| 10a. State
MD | 10b. County
Caroline | 10c. City, Town or Location
Federalsburg | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
4329 Long Swamp Road | | 10f. Zip Code
21632 | | 10g. Citizen of What Country?
United States | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9
College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Dairy & Grain Farmer | |
| 16b. Kind of Business/Industry
Agriculture | | 17. Father's Name (First, Middle, Last)
Joseph Waldis | | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Minnie Scott | | 19a. Informant's Name/Relationship (Type, Print)
Geneva L. Waldis/Spouse | | | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4329 Long Swamp Rd., Federalsburg, MD 21632 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Concord Cemetery | | 20c. Date
5/4/99 | | 20d. Location - City or Town, State
Federalsburg, MD | |
| 21. Signature of Funeral Service Licensee
Muhil J. Esbow | | 22. Name and Address of Facility
Frampton-Hawkins-Eskow Funeral Home, PA
PO Box 43, Federalsburg, MD 21632 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Aplastic anemia
Due to (or as a consequence of):
a.
b.
c.
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate interval Between Onset and Death
7d. | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart Failure
Atrial fibrillation
Sepsis | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | |
| 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Andrew A. Sparks | | 29c. License number
D35284 | |
| 29d. Date signed (Month, Day, Year)
5/7/99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ANDREA AUBN, MD 216 N. Washington St Easton MD 21629 | | | |
| 31. Date filed (Month, Day, Year)
MAY 10 1999 | | 32. Registrar's Signature
Andrew A. Sparks | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

AMEND 4a&4b #26 PER PHYN G772 6-3-99 J.A.

99 17698

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

C. D. ASHLOCK

2. Date of Death

Month Day Year
MAY 21 1999

3. Time of Death

10:30 AM

4a. Facility Name (If not institution, give street and number)

1326 AIKON AVE. UNION HOSPITAL 106 BOW STREET

4b. City, Town, or Location of Death

PERRYVILLE ELKTON MARYLAND

4c. County of Death

CECIL

5. Social Security Number

463 46 9721

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 3, 1935

9. Birthplace (State or Foreign Country)

Oklahoma

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Perryville

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

1326 Aikon Ave.

10f. Zip Code

21903

10g. Citizen of What Country?

United States

11. Marital Status

(Unknown)

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
(Unknown)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Yardman

16b. Kind of Business/Industry

Railroad

17. Father's Name (First, Middle, Last)

Clyde David

Ashlock

18. Mother's Name (First, Middle, Maiden Surname)

Annie Elizabeth Evans

19a. Informant's Name/Relationship (Type, Print)

Charles F. Henry / Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

39 Rollin Hills Ranch Ln., Port Deposit, MD 21904

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory 5/26/99

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Stephen D. Lohrmann

22. Name and Address of Facility

CAFA Stephen D. Lohrmann P.A.
8717 Green Pastures Dr., Baltimore, MD 21286

23a. Part I. Entail the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ Other

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. J. HARRISON MD.

29c. License number

800952

29d. Date signed (Month, Day, Year)

May 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Union Hospital 106 Bow St; ELKTON MD 21921

31. Date filed (Month, Day, Year)

JUN 03 1999

32. Registrar's Signature

Bruce B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17697

| | | | | | | | | | | |
|---|---|--|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BETTY ANN WOLFE | | | | | | 2. Date of Death
Month MAY 19 Day 1999 Year | | 3. Time of Death
7:44 PM | |
| | 4a. Facility Name (If not institution, give street and number)
NATIONAL NAVAL MEDICAL CENTER | | | | | | 4b. City, Town, or Location of Death
BETHESDA | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
225-44-5414 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
61 Yrs. | | 8. Date of Birth (Month, Day, Year)
11-15-37 | | 9. Birthplace (State or Foreign Country)
Virginia | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
VA | | 10b. County
-- | | 10c. City, Town or Location
Chesapeake | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number
2308 Ardmore Avenue | | | | 10f. Zip Code
23324 | | 10g. Citizen of What Country?
U.S.A. | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Caucasian | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 College (1-4or 5+) -- | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Own Home | | |
| | 17. Father's Name (First, Middle, Last)
Ernest Adams | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Flonnie Helton | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Family | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2308 Ardmore Avenue, Chesapeake, VA 23324 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowbrook Memorial Gardens | | 20c. Location - City or Town, State
Suffolk, VA | | 20d. Date
05-24-99 | |
| | 21. Signature of Funeral Service Licensee
S. Scott Stroud | | | | 22. Name and Address of Facility
GRAHAM Funeral Home
P.O. Box 5706, Chesapeake, VA 23324 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediata Cause (Final disease or condition resulting in death)

a. HEMORRHAGIC SHOCK
Due to (or as a consequence of):
b. RETROPERITONEAL BLEEDING
Due to (or as a consequence of):
c. COAGULOPATHY
Due to (or as a consequence of):
d.

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | | | | | | | |
| 28a. Date of Injury (Month, Day, Year) | | | | | | | | | | |
| 28b. Time of Injury
M | | | | | | | | | | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 28d. Describe how injury occurred | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
C.H. Meyers, MC | | | | | | | | | | |
| 29c. License number
39198 (NC) | | | | | | | | | | |
| 29d. Date signed (Month, Day, Year)
MAY 20, 1999 | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
C.H. MEYERS, LCDR, MC, USN
NATIONAL NAVAL MEDICAL CENTER
BETHESDA MD 20889-5600 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 1 1999 | | | | | | | | | | |
| 32. Registrar's Signature
Benjamin B. Sparks | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 26a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

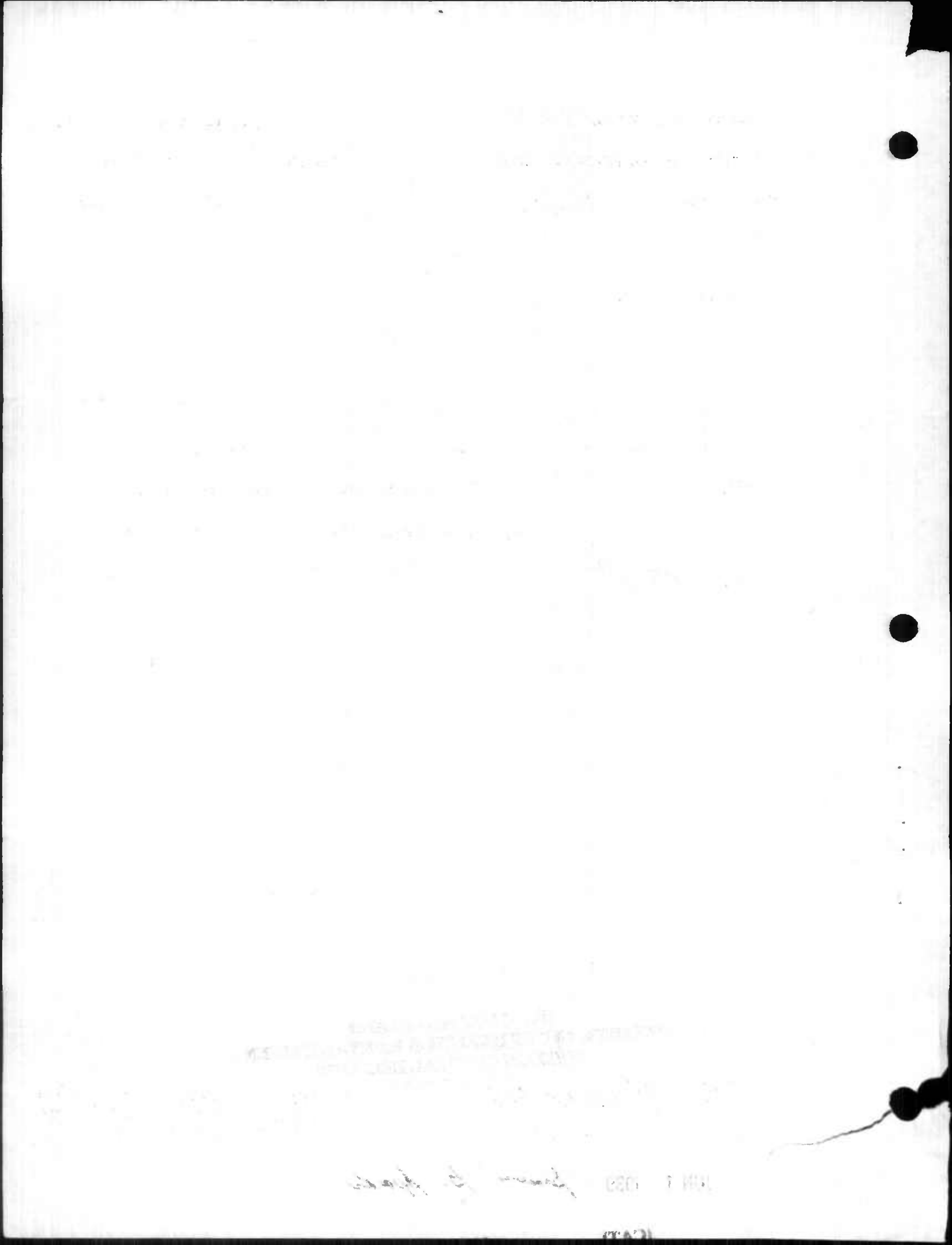
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Amended Item#10e per FH G772 6/3/99 EW

99 17699

| | | | | | | | | | | |
|---|--|---------------------------------|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BRIAN KEITH AEIKER | | | | | | 2. Date of Death
Month Day Year
MAY 27 1999 | | 3. Time of Death
7:35 AM | |
| | 4a. Facility Name (If not institution, give street and number)
11 SILVER LEAF APT. B | | | | | | 4b. City, Town, or Location of Death
COCKEYSVILLE | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
269-66-2868 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
36 Yrs. | | 8. Date of Birth (Month, Day, Year)
AUG. 25, 1962 | | 9. Birthplace (State or Foreign Country)
W. VIRGINIA | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
COCKEYSVILLE | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
11 Silver Leaf Apt B | | | | | | 10f. Zip Code
21030 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOME IMPROVEMENT | | | 16b. Kind of Business/Industry
ATOZ REPAIRS | | | |
| 17. Father's Name (First, Middle, Last)
JOHN FRANKLIN AEIKER | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
DOANA MAE RANDOLPH | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
DELBERT LAIR | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3 WARWICK MILL CT. COCKEYSVILLE, MD. 21030 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GARRISON FOREST CEMETERY | | | Date
JUNE 2, 1999 | | 20c. Location - City or Town, State
GARRISON FOREST, MD | | |
| 21. Signature of Funeral Service Licensee
<i>Heidi S. Wells</i> | | | | | | 22. Name and Address of Facility
EVANS CHAPEL OF CHIMES
2325 YORK ROAD TIMONIUM, MD. 21093 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Strangulation from Hanging
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year)
MAY 27, 1999 | | 28b. Time of Injury
7:35 AM | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred
Hanging in own Apt | |
| | | | 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)
At Home | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
APT B 11 SILVER LEAF COCKEYSVILLE, MD | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier
<i>Charles F. O'Donnell MD</i> | | | 29c. License number
D-09383 | | 29d. Date signed (Month, Day, Year)
June 1, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Charles F. O'Donnell MD 114 Hamlet Hill Rd Baltimore MD 21210 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | 32. Registrar's Signature
<i>James E. Sparks</i> | | | | | | | |

To Be Completed by Funeral Director

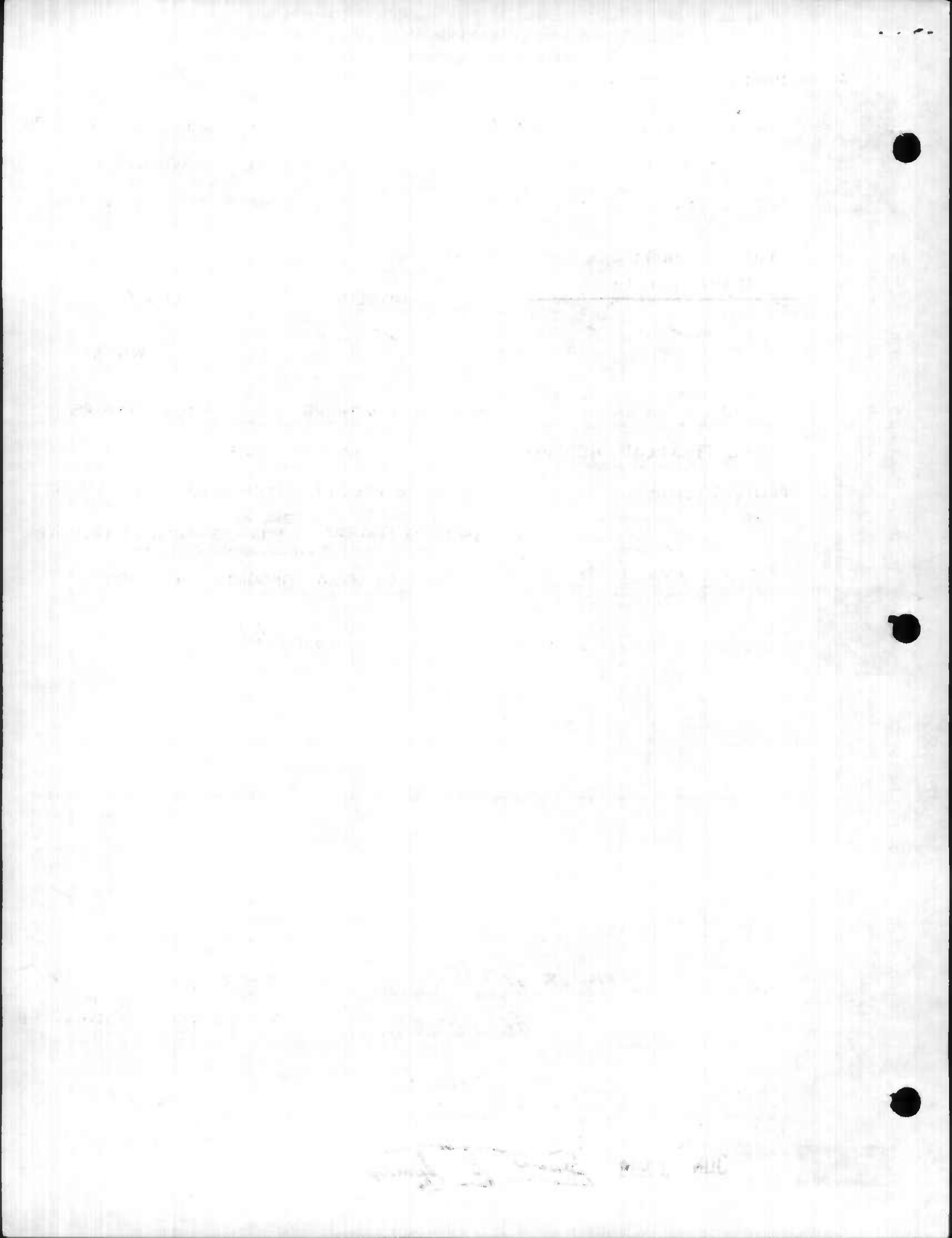
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17700

| | | | | | | | | |
|---|---|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JONES EKPENYONG ASUQUO | | | | 2. Date of Death
Month May Day 26 Year 1999 | | 3. Time of Death
11:10 PM | |
| | 4a. Facility Name (If not Institution, give street and number)
UNION MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
NIA | |
| Funeral
Director | 5. Social Security Number
242-393261 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
49 yrs. | | 8. Date of Birth (Month, Day, Year)
DEC. 29, 1949 | |
| | 9. Birthplace (State or Foreign Country)
NIGERIA | | 10a. State
MARYLAND | | 10b. County
NIA | | 10c. City, Town or Location
BALTIMORE CITY | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
3508 Elnora Avenue | | 10f. Zip Code
21213 | | 10g. Citizen of What Country?
NIGERIA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) MASTERS (5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MANAGER | | 16b. Kind of Business/Industry
MENTAL HEALTH | | | |
| | 17. Father's Name (First, Middle, Last)
EKPENYONG ASUQUO | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ARIT IBOK OKON | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
MARY ASUQUO (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3508 Elnora Avenue, Baltimore, MD. 21213 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARBUTUS CEMETERY | | 20c. Location - City or Town, State
MD-5-99 BALTIMORE, MARYLAND | | 20d. Date
16-5-99 | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE., BALTIMORE, MD. 21217 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Immediate Cause (Final disease or condition resulting in death)
sepsis | | | | Due to (or as a consequence of): | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
HIV lymphoma | | | | Due to (or as a consequence of): | | | |
| To Be Completed by Physician/Medical Examiner | respiratory failure | | | | Due to (or as a consequence of): | | | |
| | cardiac arrhythmia | | | | Due to (or as a consequence of): | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier
MD | | | | 29c. License number
AU417643529838 | | 29d. Date signed (Month, Day, Year)
May 26, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sue Rhee MD Union Memorial Hospital 201 East University Parkway Baltimore, MD 21218 | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | | 32. Registrar's Signature
 | | | |
| | State Registrar | | | | | | | |

100 3 1855
James A. Smith

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17701

| | | | | | | | | |
|--|--|--|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
IRENE AGE E | | | | 2. Date of Death
Month Day Year
MAY 31st 1999 | | 3. Time of Death
2.15 PM | |
| | 4a. Facility Name (If not institution, give street and number)
2800 SUFFOLK AVENUE | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
MD 21215 | |
| Funeral
Director | 5. Social Security Number
214-20-5252 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | 8. Date of Birth (Month, Day, Year)
07 09 19 | |
| | 9. Birthplace (State or Foreign Country)
V.A. | | 10e. State
MD | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
2800 Suffolk Ave | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6th grade
College (1-4 or 5+) na | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Domestic | | 16b. Kind of Business/Industry
Private | | | |
| | 17. Father's Name (First, Middle, Last)
Freddie McCargo | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Alease Richardson | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Laura McNair-Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2800 Suffolk Ave, Baltimore Md 21215 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Druid Ridge Cemetery | | Date
6/4/99 | | 20c. Location - City or Town, State
Baltimore, Md | |
| | 21. Signature of Funeral Service Licensee
Gabriele Cook | | | | 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore Md 21215 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. HYPERTENSIVE HEART DISEASE Months
Due to (or as a consequence of):
b. ATHEROSCLEROSIS years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
M. Vasanthakumar | | 29c. License number
D42510 | | 29d. Date signed (Month, Day, Year)
JUNE 1st 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
M. VASANTHAKUMAR MD 821. N. EUTAW ST, # 407, MD 21201 | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
JUN 3 1999 | | 32. Registrar's Signature
Seneca B. Sparks | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 17702

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|---|---|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
John F. Austin | | | | | 2. Date of Death
Month Day Year
May 28, 1999 | | 3. Time of Death
11:26 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Knollwood Manor | | | | | 4b. City, Town, or Location of Death
Millersville | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
218-03-3919 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
91 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Aug. 7, 1907 | | 9. Birthplace (State or Foreign Country)
Virginia | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Bowie | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
12304 Shafer Lane | | | | 10f. Zip Code
20720 | | 10g. Citizen of What Country?
United States | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Operational Engineer | | | 16b. Kind of Business/Industry
U.S. Government | | |
| 17. Father's Name (First, Middle, Last)
John H. Austin | | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Fanny T. Jones | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Carol G. Austin/ Wife | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12304 Shafer Lane Bowie, MD 207120 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | Data
6/1/99 | | 20c. Location - City or Town, State
Alexandria, Virginia | | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
Robert E. Evans Funeral Home, Inc.
16000 Annapolis Road Bowie, MD 20715 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. myocardial infarction hours
Due to (or as a consequence of):
b. coronary artery disease years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
cerebrovascular disease, dementia
with psychosis, dysphagia with
recurrent pneumonia, hypertension | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D41955 | | 29d. Date signed (Month, Day, Year)
6-1-99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rebecca Elton MD 479 Jumpers Hole Rd Severna Park Maryland | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

99-3087-510

jhm

MANJUSREE

BASU AMEND ITEM: #28F PER MEO G773 7-17-99 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17703

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

MANJUSREE BASU

2. Date of Death

Month Day Year
MAY 29, 1999

3. Time of Death

1030 AM

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

218-94-0075

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
OCT. 14, 1956

9. Birthplace (State or Foreign Country)

INDIA

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6 WICKMAN COURT

10f. Zip Code

21244

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: ASIAN INDIAN

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

ASSISTANT VICE PRESIDENT

16b. Kind of Business/Industry

BANKING

17. Father's Name (First, Middle, Last)

KIRANJAN ROY

18. Mother's Name (First, Middle, Maiden Summa)

KRISHNA DUTTA

19a. Informant's Name/Relationship (Type, Print)

BULA GHOSE/FRIEND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9533 CHATON ROAD, LAUREL, MARYLAND 20723

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE WASHINGTON CR.

Date

6/1/99

20c. Location - City or Town, State

LAUREL, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FLECK FUNERAL HOME, INC.

7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hanging
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

5/28/99

28b. Time of Injury

3:38 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject hanged self

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

6 WICKMAN COURT

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Baltimore County, Md

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. Pestaner, M.D.

29c. License number

OCME

29d. Date signed (Month, Day, Year)

MAY 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

James B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17704

| | | | | | | | | | | | | | | | | | | | |
|--|---|--|--|---|---|---------------------------------|--------------------------------|--|---|--|--|---|---|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MYRTLE AGNES BLOUSE | | | | 2. Date of Death
Month MAY Day 28 Year 1999 | | | | 3. Time of Death
10:00pm | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
STELLA MARIS HOSPICE | | | | 4b. City, Town, or Location of Death
TIMONIUM | | | | 4c. County of Death
BALTIMORE | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
212-12-5348 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
91 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | 8. Date of Birth (Month, Day, Year)
AUG 24, 1907 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | | | | | |
| | Usual Residence of Decedent | | | | 10a. State
MARYLAND | | | | 10b. County
BALTIMORE | | | | 10c. City, Town or Location
TIMONIUM | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
226 SANDEE ROAD | | | | 10f. Zip Code
21093 | | | | 10g. Citizen of What Country?
U.S.A. | | | | | | | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6TH GRADE | | | | College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | | | 16b. Kind of Business/Industry
OWN HOME | | | | | | | |
| 17. Father's Name (First, Middle, Last)
GEORGE CUNNINGHAM | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ELIZABETH DUKES | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
ELIZABETH POULAS (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
226 SANDEE ROAD - TIMONIUM, MARYLAND 21093 | | | | | | | | | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
LOUDON PARK CEMETERY | | | | Date
6/1/99 | | | | 20c. Location - City or Town, State
BALTIMORE, MARYLAND | | | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
HUBBARD FUNERAL HOME, INC.
4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229 | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | Approximate Interval Between Onset and Death | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | | | | | | | | | | | | | | | | | | |
| a. VAGINAL BLEEDING
Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | |
| b. CERVICAL CANCER
Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | |
| c.
Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | |
| d.
Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| | | | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
 No? | | | | 29c. License number
D 15504 | | 29d. Date signed (Month, Day, Year)
6-01-99 | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093 | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | | 32. Registrar's Signature
 | | | | | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

NAME: BLOUSE, MYRTLE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17705

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD LEEMAN BUFFINGTON, SR.

2. Date of Death

Month
MAYDay
29Year
1999

3. Time of Death

2:05 PM

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

212-16-8924

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 6, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

XX Yes 2□ No

10e. Street and Number

1228 Union Avenue

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

1□ Never Married XX Married
3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1□ Yes XX No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes XX No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
6

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Edward T. Buffington

18. Mother's Name (First, Middle, Maiden Surname)

Dora Emily Cockey

19a. Informant's Name/Relationship (Type, Print)

Mildred Ruth Buffington Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1228 Union Avenue Baltimore, MD 21211

20a. Method of Disposition

1XX Burial 2□ Cremation 3□ Removal from State
4□ Donation 5□ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lorraine Park Cemetery

Date

6/2/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, Maryland 2121123a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

MYOCARDIAL INFARCTION

Due to (or as a consequence of):

18 hours

b.

COMPLETE HEART BLOCK

Due to (or as a consequence of):

5 days

c.

UPPER GASTROINTESTINAL BLEED

Due to (or as a consequence of):

5 days

d.

CORONARY ARTERY DISEASE

20 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2□ No 3□ Probably 4□ Unknown

24a. Was an autopsy
performed?

1□ Yes 2□ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1□ Yes 2□ No

25. Was case referred to medical
examiner?

1□ Yes 2□ No

Hospital:

1□ Inpatient

2□ ER/Outpatient

3□ DOA

Other:

4□ Nursing Home 5□ Residence 6□ Other (Specify)

27. Manner of Death

1□ Natural 5□ Pending
investigation
2□ Accident 6□ Could not be
determined
3□ Suicide
4□ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury28c. Injury at
Work?

1□ Yes 2□ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1□ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

P12344

29d. Date signed (Month, Day, Year)

MAY 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARLA WATSON 2401 WEST BELVEDERE AVENUE BALTIMORE, MARYLAND 21215

31. Date filed (Month, Day, Year)

JUN 03 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitState
Registrar

Please Type or Print in **Black Indelible Ink**. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17707

| | | | | | | | | | |
|--|--|--|---|--|--|---|---|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LARRY BRANDFORD | | | | | 2. Date of Death
Month Day Year
MAY 29 1999 | | 3. Time of Death
2:52 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center | | | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
216-60-5820 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
46 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
8-14-52 | | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD. | | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
897 W. LOMBARD ST | | | | | 10f. Zip Code
21223 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
DOORMAN | | | 16b. Kind of Business/Industry
WASHINGTON PARK APTS. | |
| 17. Father's Name (First, Middle, Last)
HERBERT BRANDFORD | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
JANIC MAE. SMITH | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
CORNELIA BRANDFORD | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
897 W. LOMBARD ST. BALTIMORE MARYLAND 21223 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
CEDAR HILL CEMETERY | | | 20c. Location - City or Town, State
6-3-99 BALTIMORE MARYLAND | | | |
| 21. Signature of Funeral Service Licensee
<i>Lloyd M. Estes</i> | | | | | 22. Name and Address of Facility
ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PLACE BALTIMORE MARYLAND 21217 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
PONTINE HEMMORHAGE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
HYPERTENSION

a. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | | Approximate Interval Between Onset and Death
4 DAYS

YEARS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | | |
| | | | | | | | 24a. Was an autopsy performed?
1 Yes 2 No | | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | | |
| 25. Was case referred to medical examiner?
1 Yes 2 No | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | | 28d. Describe how injury occurred |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Timothy Low M.D.</i> | | | | | 29c. License number
D 24034 | | 29d. Date signed (Month, Day, Year)
5/29/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TIMOTHY LOW M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 03 1999 | | | 32. Registrar's Signature
<i>Barbara B. Sparks</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

AMEND#24a&25 PER PHYN G772 6-3-99 J.A.

99 17708

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|--|--|--|--|---|--------------------------------|---|--|
| 1. Decedent's Name (First, Middle, Last)
Leslie J. Blaxland | | | | 2. Date of Death
Month May Day 22 Year 1999 | | 3. Time of Death
4:45 am | |
| 4a. Facility Name (If not institution, give street and number)
Bobbie Hospice of Chesapeake | | | | 4b. City, Town, or Location of Death
Pasadena | | 4c. County of Death
Anne Arundel | |
| 5. Social Security Number
217-34-6106 | | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
59 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Oct. 6, 1939 | |
| 9. Birthplace (State or Foreign Country)
Arkansas | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Pasadena | | 10d. Inside City Limits
1 Yes 2 No | |
| 10e. Street and Number
70 Milburn Circle | | | | 10f. Zip Code
21122 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
secretary | | 16b. Kind of Business/Industry
Title Company | |
| 17. Father's Name (First, Middle, Last)
Lester Tillhman Moore | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lillie Marie Hinton Gibson | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Sherry Ann Woodland/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
70 Milburn Circle, Pasadena, MD 21122 | | | |
| 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee
Ronald S. Wade, Director | | | | 22. Name and Address of Facility
State Anatomy Board, 655 W. Baltimore Street
Baltimore, MD 21201 | | | |

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

| | | |
|---|--|---|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Pancreatic Carcinoma
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
3 mos. |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of): | | |
| c.
Due to (or as a consequence of): | | |
| d.
Due to (or as a consequence of): | | |

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | | | |
| | | | | 24a. Was an autopsy performed?
1 Yes 2 No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | |
| 25. Was case referred to medical examiner?
1 Yes 2 No | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. Manner of Death
1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | |
| | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | | 28f. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier
Russell A. DeLuca | | | | 29c. License number
031551 | | 29d. Date signed (Month, Day, Year)
May 25, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Russell A. DeLuca, 1600 S. Craig Highway, Glen Burnie, N. 21061 | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 03 1999 | | | | 32. Registrar's Signature
B. Sparks | | | |

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17709

| | | | | | | | | | |
|---|---|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES BURRELL | | | | 2. Date of Death
Month Day Year
JUNE 1 1999 | | 3. Time of Death
6:13 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
UNIVERSITY of MARYLAND MEDICAL SYSTEMS | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
214-44-7024 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
52 Yrs. | | 8. Date of Birth (Month, Day, Year)
APRIL 15, 1947 | | |
| | 9. Birthplace (State or Foreign Country)
VIRGINIA | | 10a. State
MARYLAND | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE CITY | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
2102 BAKER STREET | | 10f. Zip Code
21217 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10TH GRADE | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
LABORER | | 16b. Kind of Business/Industry
DAVIDSON & CHEMICAL | | | |
| 17. Father's Name (First, Middle, Last)
JAMES | | | | 18. Mother's Name (First, Middle, Maiden Surname)
BURRELL GERTRUDE RANDALL | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
MADGELENE BURRELL (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2102 BAKER ST. BALTIMORE, MD. 21217 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
KING MEM. PARK | | 20c. Location - City or Town, State
06-05-99 WOODLAWN, MD. | | 20d. Date | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE. BALTO. MD. 21217 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. MULTIORGAN SYSTEM FAILURE
Due to (or as a consequence of):

f. SEVERE PNEUMONIA
Due to (or as a consequence of):

g.
Due to (or as a consequence of):

h.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death

3 DAYS

1 WEEK | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. Place of Death (Check only one)
Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
P11214 | | 29d. Date signed (Month, Day, Year)
JUNE 1, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
CHRISTINA LI UNIV. OF MD MEDICAL SYST., 22 S. GREENE ST., DEPT OF SURGERY, BALTIMORE MD 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | 32. Registrar's Signature
 | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17710

| | | | | | | | | |
|---|---|---|--|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES BURLEY | | | | 2. Date of Death
Month Day Year
MAY 27th 1999 | | 3. Time of Death
1:07 PM | |
| | 4a. Facility Name (If not institution, give street and number)
HARBOR HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
218-26-0109 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
68 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
Month Day Year
FEB. 24, 1931 | | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | Usual Residence of Decedent
MARYLAND A. A. COUNTY | | | | 10c. City, Town or Location
GLEN BURNIE | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10a. State
MARYLAND | | 10b. County
A. A. COUNTY | | 10e. Street and Number
7960 CRAINMONT DRIVE | | 10f. Zip Code
21061 | | 10g. Citizen of What Country?
USA |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th GRADE College (1-4 or 5+) DEBURRER | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
WESTINGHOUSE CO. | | 16b. Kind of Business/Industry | | |
| 17. Father's Name (First, Middle, Last)
DORY WINFIELD BURLEY | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ARMANELLA QUEEN | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
BERNICE BURLEY (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7960 CRAINMONT DR. GLEN BURNIE MD. 21061 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ST. REST CEMETERY | | 20c. Date
06-02-99 | | 20d. Location - City or Town, State
GLEN BURNIE MARYLAND | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
JOSEPH H. BROWN JR. FUNERAL HOME
3140 N. FULTON AVE., BALTIMORE, MD 21217 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE CARDIAC FAILURE
Due to (or as a consequence of):
b. MYOCARDIAL INFARCTION
Due to (or as a consequence of):
c. SEVERE PERIPHERAL VASCULAR DISEASE WITH DRY GANGRENE
Due to (or as a consequence of):
d. | | | | | | | | Approximate Interval Between Onset and Death
ONE MONTH |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SEPSIS | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
 RESIDENT, INTERNAL MED. | | 29c. License number
P 13130 | | 29d. Date signed (Month, Day, Year)
MAY 27th 1999 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. BALASUBRAMANIAN JAYALAKSHMI, 3001 S. HANOVER STREET, BALTIMORE, MD 21225 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #23a PER M.D. G772 6/3/99 AH

Certificate of Death

Reg. No.

99 17711

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDITH R. BROWN

2. Date of Death

Month

Day

Year

5

26

1999

3. Time of Death

11:37 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL, MD.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

5. Social Security Number

213307156

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months

if Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

3/3/32

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5039 THE ALAMEDA

10f. Zip Code

21239

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH GRADE

College (14 or 5+)

5 + 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MASTER TEACHER

16b. Kind of Business/Industry

BALTO. CITY PUBLIC SCHOOLS

17. Father's Name (First, Middle, Last)

SOLOMON

18. Mother's Name (First, Middle, Maiden Surname)

RICKS GRACIE EDITH HAMLIN

19a. Informant's Name/Relationship (Type, Print)

ROOSEVELT BROWN (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5039 THE ALAMEDA, BALTIMORE, MD. 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST CEMETERY

Date

06-01-99

20c. Location - City or Town, State

OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee

JOSEPH H. BROWN JR. FUNERAL HOME

22. Name and Address of Facility

2140 N. FULTON AVE., BALTO., MD. 21217

23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. (List only one cause on each line)

HYPERTENSIVE CARDIOVASCULAR DISEASE

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Cardiac Arrest

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Left ventricular hypertrophy

Small thromboembolus, R. gut lower lobe

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

M

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5

29a. Certifier (Check only one)

1 ☒ Physician 2 ☐ Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sheldon M. Glusman MD

29c. License number

D08734

29d. Date signed (Month, Day, Year)

5/27/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Sheldon M. Glusman MD

GOOD SAMARITAN HOSPITAL, BALTO., MD

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17712

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Samuel Bruton Jr.

2. Date of Death

May 24 1999

3. Time of Death

10:15 pm

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

240-36-0378

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

03 21 27

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll Co.

10c. City, Town or Location

Hanover

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1462 Gesha Drive

10f. Zip Code

21076

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6th grade

College (1-4 or 5+)

na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Presser

16b. Kind of Business/Industry

Dry Cleanings Bus.

17. Father's Name (First, Middle, Last)

Samuel Bruton Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Sallie Mae Cherry

19a. Informant's Name/Relationship (Type, Print)

William Williams-Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1462 Gesha Drive, Hanover Md 21076

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Hill Cemetery

Date

6/2/99

20c. Location - City or Town, State

Candor, N.C.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

March F/H West
4300 Wabash Ave, Baltimore Md 21215

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

Ten days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Stroke, atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature], MD

29c. License number

D48006

29d. Date signed (Month, Day, Year)

May 24th, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kofi Bonifay, 301 Hwy. Dr, Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

[Signature]

State
Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

100 1 1833

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 17713

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|---|---|---------------------------------|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Lucille Brown | | | | 2. Date of Death
Month May Day 30 Year 1999 | | | | 3. Time of Death
13:26 | |
| | 4a. Facility Name (If not institution, give street and number)
Sinai Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
212-32-1778 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
72 Yrs. | | 8. Date of Birth (Month, Day, Year)
07 08 26 | | 9. Birthplace (State or Foreign Country)
V.A. | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number
3624 Manchester Ave | | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
U.S.A. | | | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6th grade College (14 or 5+) na | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Domestic Worker | | | | 16b. Kind of Business/Industry
Private | |
| | 17. Father's Name (First, Middle, Last)
Ball | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Alice Norris | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Wilson Smith-Friend | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3624 Manchester Ave, Baltimore Md 21215 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cemetery | | Date
6/3/99 | | 20c. Location - City or Town, State
Baltimore, Md | | | |
| | 21. Signature of Funeral Service Licensee
<i>File March</i> | | | | 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore Md 21215 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CARDIORESPIRATORY ARREST
Due to (or as a consequence of):
b. HYPERTENSIVE HEART DISEASE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown

24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
WALTER J. SMITH MD | | | | 29c. License number
024468 | | 29d. Date signed (Month, Day, Year)
6-1-99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
WALTER J. SMITH MD 3502 W ROBERT AVE BALTIMORE MD | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | 32. Registrar's Signature
<i>B. Sparks</i> | | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, 27, 28A-F PER MEO G773 7-8-99 WR. Certificate of Death

Reg. No.

99 17714

| | | | | | | | | |
|---|--|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Toteayawna Brand | | | | 2. Date of Death
Month Day Year
MAY 27, 1999 | | 3. Time of Death
0831 AM | |
| | 4a. Facility Name (If not institution, give street and number)
JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
unk | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
Yrs. 29 | If Under 1 Year
Months 29 | If Under 24 Hrs.
Hours 29 Min. | 8. Date of Birth (Month, Day, Year)
April 28, 1999 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
411 E. 20th St. | | 10f. Zip Code
21218 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Afro-American | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) N/A College (14 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Baby | | 16b. Kind of Business/Industry
N/A | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
William Rose | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Tyresha Brand | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Lorie Brand | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
411 E. 20th St. Balto. Md. 21218 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Voshell Mem. Gardens | | 20c. Location - City or Town, State
Dundalk, Md. | | 20d. Date
6/5/99 | |
| | 21. Signature of Funeral Service Licensee
Joseph L. Russ | | 22. Name and Address of Facility
Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216 | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
CHILD ABUSE WITH BRAIN INJURIES AND SKELETAL FRACTURES | | | | | | | |
| | Due to (or as a consequence of):
a.
b.
c.
d.
Due to (or as a consequence of):
Due to (or as a consequence of): | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
Found: 5-27-99 | | 28b. Time of Injury
Found: 7:55 A M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred
ASSAULTED | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
FOUND AT HOME | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)
411 E. 20TH STREET BALTO. CITY, MD. | | | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Joseph Rustan, M.D. | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 28, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Rustan 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | | 32. Registrar's Signature
John A. Sparks | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

6:35 P.M.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert E. Babcock, Sr.

2. Date of Death

Month Day Year
May 29, 1999

3. Time of Death

6:35 P.M.

4a. Facility Name (If not institution, give street and number)

Gilchrist Hospice Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore County

Funeral
Director

5. Social Security Number

005-22-4170

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 31, 1927

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Monkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15011 LaVale Rd.

10f. Zip Code

21111

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: '46-67

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

United States Army - Major

16b. Kind of Business/Industry

Military

17. Father's Name (First, Middle, Last)

Morrell Babcock

18. Mother's Name (First, Middle, Maiden Surname)

Monica McDonald

19a. Informant's Name/Relationship (Type, Print)

Phyllis Babcock / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15011 LaVale Rd., Monkton, Maryland 2111

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Gar.

Date

June 4, 1999

20c. Location - City or Town, State

Timonium, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Kirkley-Ruddick Funeral Home, P.A.

421 Crain Hwy., S.E., Glen Burnie, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. pulmonary edema & coronary insuff. 2 wks

Due to (or as a consequence of):

b. metastatic head + neck carcinoma 14 yrs (tongue)

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ileus, Hypertension, atherosclerotic cardiovascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D28594

29d. Date signed (Month, Day, Year)

May 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ruth Kantor, M.D., 6569 N. Charles St., Suite 210, Baltimore, MD 21401

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

State
Registrar

6:35 pm

5/29/99

Babcock, Robert

AH 15

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17716

| | | | | | | | | |
|---|---|---|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Sara Adeline Bonnett | | | | 2. Date of Death
Month Day Year
MAY 29, 1999 | | 3. Time of Death
7:00 PM | |
| | 4a. Facility Name (If not institution, give street and number)
FRANKLIN Square Hospital Center | | | | 4b. City, Town, or Location of Death
Rosedale | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
236-28-1531 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 23, 1920 | |
| | 9. Birthplace (State or Foreign Country)
West Virginia | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Dundalk | |
| 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
3122 Liberty Parkway | | 10f. Zip Code
21222 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 Years
College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Factory Worker | | 16b. Kind of Business/Industry
Manufacturing | | | | |
| 17. Father's Name (First, Middle, Last)
George Smith | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sara Puffenberger | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mr. Argel E. Bonnett/Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3122 Liberty Parkway Dundalk, Maryland 21222 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Mausoleum | | Date
6/2/1999 | | 20c. Location - City or Town, State
Glen Burnie, MD | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>Uremia</u>
Due to (or as a consequence of):</p> <p>b. <u>Renal Failure</u>
Due to (or as a consequence of):</p> <p>c. <u>Sepsis</u>
Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 35%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p>24 hours</p> <p>24 hours</p> <p>5 DAYS</p> </div> </div> | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
, PHYSICIAN | | | | 29c. License number
D 53547 | | 29d. Date signed (Month, Day, Year)
5/29/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sanjay Jagannath M.D. 9000 Franklin Square Drive, Baltimore MD. 21237 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 3 1999 | | 32. Registrar's Signature
 | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ADH
ROBERT M. BLACKERT
99-5116-011

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17717

ITEMS: #23 PART I, 27, 28A-F PER MEO

| | | | | | | | | | | | |
|---|---|------------------------|---|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Robert Michael Blackert | | | | 2. Date of Death
Month Day Year
MAY 30, 1999 | | 3. Time of Death
1630 PM | | | | |
| | 4a. Facility Name (If not institution, give street and number)
2072 HAMMOND AVENUE | | | 4b. City, Town, or Location of Death
MARRIOTTSTVILLE | | 4c. County of Death
CARROLL | | | | | |
| Funeral
Director | 5. Social Security Number
220-46-8639 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
38 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 11, 1960 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Carroll | | 10c. City, Town or Location
Marriottsville | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
2072 Hammond Ave. | | | | 10f. Zip Code
21104 | | 10g. Citizen of What Country?
United States | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
College (1-4 or 5+)
2 years | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Data Base Manager | | | 16b. Kind of Business/Industry
I.H.S. | | | | |
| 17. Father's Name (First, Middle, Last)
Albert R. Blackert | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Louise L. Helms | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Catherine V. Blackert Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2072 Hammond Ave. Marriottsville, MD 21104 | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View Mem. Park | | 20c. Location - City or Town, State
6/2/99 Sykesville, MD | | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
Burrier-Queen Funeral Directors, P.A.
1212 W. Old Liberty Road Winfield, MD 21784 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. HEAT STROKE
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | |
| | | | | | | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input checked="" type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year)
5-30-99 | | 28b. Time of Injury
UNKNOWN M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
OVEREXPOSURE TO HEAT | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
YARD OF RESIDENCE | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
2072 HAMMOND AVE.
MARRIOTTSTVILLE, CARROLL COUNTY, MD. | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
MAY 31, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

SANDRA LYNN BUCKNER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17718

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SANDRA LYNN BUCKNER

2. Date of Death

Month Day Year
MAY 29, 1999

3. Time of Death

16:20 PM

4a. Facility Name (If not institution, give street and number)

2963 EAST NECK ISLAND ROAD

4b. City, Town, or Location of Death

4c. County of Death

KENT

Funeral
Director

5. Social Security Number

214.80.5785

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

30

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
7/11/1968

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

22 MAIN AVENUE, SW

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

72

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

HARRY A. TAYLOR

18. Mother's Name (First, Middle, Maiden Surname)

MARY E. TAYLOR

19a. Informant's Name/Relationship (Type, Print)

RICHARD M. BUCKNER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22 MAIN AVE., SW, GLEN BURNIE, MD 21061

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GLEN HAVEN MEM. PARK.

Data

6/2

20c. Location - City or Town, State

GLEN BURNIE, MD

21. Signature of Funeral Service Licensee

KELLY GREGORY FINK

22. Name and Address of Facility

FINK FUNERAL HOME, P.A.

426 CRAIN HWY., SW., GLEN BURNIE, MD 21061

23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Drowning
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. _____
Due to (or as a consequence of):c. _____
Due to (or as a consequence of):

d. _____

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☒ Other (Specify) SCENE

27. Manner of Death

☐ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☒ Suicidal ☐ Homicidal

28a. Date of Injury (Month, Day, Year)

FOUND 5-29-99

28b. Time of Injury

4:20 PM

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

SUSPECT JUMPED FROM BRIDGE

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

BODY OF WATER BY BRIDGE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

FOUND EAST WALKER, KENT CO, MD

29a. Certifier (Check only one)

☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Maureen D. McKel

29c. License number

OCME

29d. Date signed (Month, Day, Year)

MAY 30, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. A. R. Jones

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUN - 3 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17719

AMENDED ITEM #8 PERFFH G772 6/3/99 AH

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Milton

John

Borkowski

2. Date of Death

Month

Day

Year

MAY

29

1999

3. Time of Death

7:20 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

215-10-9457

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88

8. Date of Birth

1910

9. Birthplace (State or Foreign Country)

Sept 20 1999

10. Inside City Limits

Deleware

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10e. Street and Number

6815

Brentwood Avenue

10f. Zip Code

21222

10g. Citizen of What Country?

U.S. of America

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1929

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Pipe Fitter

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Francis

18. Mother's Name (First, Middle, Maiden Surname)

Borkowski

19. Informant's Name/Relationship (Type, Print)

Rose

19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Pszzlyseska

19a. Informant's Name/Relationship (Type, Print)

Milton F. Borkowski (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13321 Springwood Court Ellicott, Md. 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St' Stanislaus

Date

June

2

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Mark A. Wojnicki

22. Name and Address of Facility

W. Dabrowski-Chojnacki F.H.'s P.A.

1005 Dundalk Ave. Balto., Md. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

6 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M T

29c. License number

D21859

29d. Date signed (Month, Day, Year)

May 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohammad Tagi M.D. 9000 Franklin Square Dr. Baltimore MD 21237

31. Date filed (Month, Day, Year)

JUN - 3 1999

32. Registrar's Signature

Sparks

State
Registrar

Borkowski, Milton

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17720

| | | | | | | | | | |
|---|--|---|---|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Thelma L. Cook | | | | 2. Date of Death
Month May Day 29 , Year 1999 | | 3. Time of Death
5:50AM | | |
| | 4a. Facility Name (If not institution, give street and number)
Hill Haven Nursing Home | | | | 4b. City, Town, or Location of Death
Adelphi | | 4c. County of Death
Prince George | | |
| Funeral
Director | 5. Social Security Number
038-03-5668 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
88 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Oct. 22, 1910 | 9. Birthplace (State or Foreign Country)
Rhode Island | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD | | 10b. County
Prince George | | 10c. City, Town or Location
Laurel | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
12007 Dove Circle | | | | 10f. Zip Code
20708 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | | |
| 17. Father's Name (First, Middle, Last)
Herbert Jones | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Emily Fuller | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Jeanne Kelleher/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12007 Dove Circle, Laurel, Maryland 20708 | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Washington Cr. | | Date
5/31/99 | | 20c. Location - City or Town, State
Laurel, Maryland | | | |
| 21. Signature of Funeral Home Licensee
 | | | | 22. Name and Address of Facility
Fleck Funeral Home, Inc.
7601 Sandy Spring Road, Laurel, MD 20707 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or multi-organ failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. {
c. {
d. { | | | | | | | | Approximate Interval Between Onset and Death
MONTHS. | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DEMENTIA
CEREBROVASCULAR ACCIDENT | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certificate (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
825009 | | 29d. Date signed (Month, Day, Year)
MAY 30, 1999. | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Pam Mulshine, M.D. 11251 Lockwood Drive, Silver spring, Maryland 20901 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | | 32. Registrar's Signature
 | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

AT46

Page 10

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

17721

| | | | | | | | | |
|--|--|---|--|--|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Irene B. Cassort | | | | 2. Date of Death
Month MAY Day 31 , Year 1999 | | 3. Time of Death
6:10 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center | | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
213-18-0581 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
76 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Jan. 14, 1923 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Towson | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
531 Stevenson Lane | | | | 10f. Zip Code
21286 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) unknown College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Waitress | | | 16b. Kind of Business/Industry
Food Service | |
| 17. Father's Name (First, Middle, Last)
Scott L. Mason | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Gladys Mae Boyd | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Lenora Leavitt Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6028 Old Harford Road Baltimore, MD 21214 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery | | 20c. Location - City or Town, State
Baltimore, Maryland | | Date
6/2/99 |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls road Baltimore, Maryland 21211 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

SEVERE CHRONIC OBSTRUCTIVE LUNG DISEASE
a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

TYPE II DIABETES MELLITUS

CONGESTIVE HEART FAILURE | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) | | | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D 37254 | | 29d. Date signed (Month, Day, Year)
5/31/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BOON P. LIM, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 03 1999 | | 32. Registrar's Signature
 | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17722

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|---|--|--|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)
WILLIAM CAMPBELL | | | | 2. Date of Death
Month 5 Day 27 Year 99 | | 3. Time of Death
8:20 AM | |
| 4a. Facility Name (If not institution, give street and number)
BON SECOURS HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death | |
| 5. Social Security Number
212-05-9884 | | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
88 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
2-22-11 | |
| 9. Birthplace (State or Foreign Country)
MD. | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State
MD. | | 10b. County
BALTIMORE | | 10c. City, Town or Location | | 10d. Inside City Limits
1 X Yes 2 No | |
| 10e. Street and Number
3147 LEEDS STREET | | | | 10f. Zip Code
21229 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
1 X Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
WELDER | | 16b. Kind of Business/Industry
BETHLEHEM STEEL | | | |
| 17. Father's Name (First, Middle, Last)
SAMUEL CAMPBELL | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MARGARET E. DORSEY | | | |
| 19a. Informant's Name/Relationship (Type, Print)
CHARLES J. JOHNSON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
614 CHAPLEGATE LANE BALTIMORE MARYLAND 21229 | | | |
| 20a. Method of Disposition
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
LOUDEN PARK CEMETERY | | Date
6-1-99 | | 20c. Location - City or Town, State
BALTIMORE MARYLAND | |
| 21. Signature of Funeral Service Licensee
Lloyd M. Esty | | | | 22. Name and Address of Facility
ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTIMORE MARYLAND 21217 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
CANCER OF THE LUNG
Due to (or as a consequence of):
RESPIRATORY FAILURE
Due to (or as a consequence of):
CEREBROVASCULAR ACCIDENT
Due to (or as a consequence of):
Pneumonia | | | | | | | |
| Approximate Interval Between Onset and Death | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ANEMIA
THROMBOCYTOPENIA
COPD | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 X Yes 2 No 3 Probably 4 Unknown | |
| 24a. Was an autopsy performed?
1 Yes 2 No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | | | | | |
| 25. Was case referred to medical examiner?
1 Yes 2 No | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. Manner of Death
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier
Woreta m | | 29c. License number
D31905 | | 29d. Date signed (Month, Day, Year)
5/27/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
AMBACHEW WORETA M D 2431 MARYLAND AVE BALTO, MD 21218 | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 03 1999 | | 32. Registrar's Signature
Benjamin G. Sparks | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

AMEND ITEMS: #1, 23 PART I, 27 PER MEO G773 7-21-99 WR,

99 17723

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SHAYQUAN M. CLAY

2. Date of Death

Month Day Year

May 24, 1999

3. Time of Death

8:45 A.M.

4a. Facility Name (If not institution, give street and number)

Harbor Hospital Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

NONE

6. Sex

15 M 20 F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

1-16-99

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

X Yes 20 No

10e. Street and Number

2808 N. DURHAM CIRCLE

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
 If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

none

16b. Kind of Business/Industry

none

17. Father's Name (First, Middle, Last)

ANOTHONY WILSON

18. Mother's Name (First, Middle, Maiden Surname)

IESHIA CLAY

19a. Informant's Name/Relationship (Type, Print)

IESHIA CLAY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2808 N. DURHAM CIR BALTIMORE MARYLAND. 21225

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WESTERN STAR

Date

5-28-99

20c. Location - City or Town, State

BALTIMORE MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.

1300 EUTAW PLACE BALTIMORE, MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SUDDEN INFANT DEATH SYNDROME

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

☐ Inpatient ☒ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute, MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUN 03 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17726

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Georgia Constantinides

2. Date of Death

May 28, 1999

3. Time of Death

7:20 pm

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

218-07-7907

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 06 1922

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

28 West Allegheny Ave. #2001

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Business Owner

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Nicholas C. Koutsoukos

18. Mother's Name (First, Middle, Maiden Surname)

Peggy Contos

19a. Informant's Name/Relationship (Type, Print)

Mrs. Aphrodite Liebno/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

210 Locknell Rd. Timonium, MD. 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Mem. Park

Date

6-2-99

20c. Location - City or Town, State

Parkville, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, MD. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. STEPS IS

Due to (or as a consequence of):

b. STAPHYLOCOCCAL PNEUMONIA

Due to (or as a consequence of):

c. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

d. SJO GREN'S SYNDROME

Approximate Interval Between Onset and Death

4 days

1 WEEK

2 MONTHS

25 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

RAMANA GOPALAN MD

29c. License number

D 0051228

29d. Date signed (Month, Day, Year)

5/29/1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

RAMANA GOPALAN MD 2 E ROLLING PROSSROADS #159 MD 21228

31. Date filed (Month, Day, Year)

JUN - 3 1999

32. Registrar's Signature

B. Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Constantinides, Georgia

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 17725
Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
James Sidney Clark, Sr. | | | | 2. Date of Death
Month Day Year
May 31 1999 | | 3. Time of Death
5:00 AM | |
| | 4a. Facility Name (If not institution, give street and number)
8228 Chestnut Avenue | | | | 4b. City, Town, or Location of Death
Bowie | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
579-12-5745 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
78 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb. 24, 1921 | |
| | 9. Birthplace (State or Foreign Country)
New Jersey | | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Bowie | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
8228 Chesnut Ave | | 10f. Zip Code
20715 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Funeral Director | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Pipe Fitter | | 16b. Kind of Business/Industry
Railroad | | | |
| | 17. Father's Name (First, Middle, Last)
Joshua Thomas Clark | | 18. Mother's Name (First, Middle, Maiden Summa)
Mary Diddy | | 19a. Informant's Name/Relationship (Type, Print)
Joshua Clark/Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12904 9th Street Bowie, MD 20720 | |
| To Be Completed by Funeral Director | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veteran's Cem. | | 20c. Location - City or Town, State
Cheltenham, MD | | 20d. Date
6/3/99 | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Robert E. Evans Funeral Home, Inc
16000 Annapolis Road Bowie, MD 20715 | | 23a. Part I: Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Terminal Cancer of Pancreas months
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertensive Cardiovascular Disease
Diabetes Mellitus type Two | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and Title of certifier
Rakesh Anand, MD | |
| To Be Completed by Physician/Medical Examiner | 29c. License number
D20108 | | 29d. Date signed (Month, Day, Year)
6/1/99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
14300 Gallant Fox Lane Bowie MD Suite 222 | | 31. Date filed (Month, Day, Year)
JUN 3 1999 | |
| | 32. Registrar's Signature
B. Sparks | | 33. State Registrar
JUN 3 1999 | | 34. DHMH 16 Rev 6/95 | | ORIGINAL | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17726

| | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Marie Helen Canatella | | | | 2. Date of Death
Month Day Year
June 01, 1999 | | | | 3. Time of Death
3:15 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death
Rosedale | | | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
215-16-0283 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
76 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 28, 1923 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Middle River | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
1401 Shore Road | | | | 10f. Zip Code
21220 | |
| | 10g. Citizen of What Country?
U.S.A. | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (14 or 5+) College (14 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | | | 16b. Kind of Business/Industry
Own Home | | | | 17. Father's Name (First, Middle, Last)
William Brecht | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Louise Kern | | | | 19a. Informant's Name/Relationship (Type, Print)
Beverly A Scopel (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7 Country Road, York, Pennsylvania 17404 | |
| Physician
/Medical
Examiner | 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 6/4/1999 | | | | 20c. Location - City or Town, State
Baltimore, Maryland | |
| | 21. Signature of Funeral Service Licensee
John W. Burkowski | | | | 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A.
1407 Old Eatsern Avenue, Essex, Maryland 21221 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

s. Ventricular Fibrillation
Due to (or as a consequence of):
b. Acute Myocardial Infarction
Due to (or as a consequence of):
c. Coronary Artery Disease
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last | |
| | Approximate Interval Between Onset and Death
1 hour | | | | Approximate Interval Between Onset and Death
24 hours | | | | Approximate Interval Between Onset and Death
10 years | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year)
June 01, 1999 | | | | 28b. Time of Injury
M | |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
[Signature] | | | | 29c. License number
D22620 | |
| | 29d. Date signed (Month, Day, Year)
June 01, 1999 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Shahid Saeed, 9000 Franklin Square Drive, Baltimore, Maryland 21237 | | | | 31. Data filed (Month, Day, Year)
JUN 03 1999 | |
| | 32. Registrar's Signature
[Signature] | | | | 33. Registrar's Name
B. Sparks | | | | 34. Registrar's Title
Registrar | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17727

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at 5055.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | |
|--|--|--|---|---|---|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
CHARLES C. CONSTANTINE | | | | | | 2. Date of Death
Month MAY Day 31 , Year 1999 | | 3. Time of Death
4:01 AM | |
| 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center | | | | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore | |
| 5. Social Security Number
091-12-3274 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
77 | 8. Date of Birth (Month, Day, Year)
Mar. 2, 1922 | 9. Birthplace (State or Foreign Country)
N.Y. | | | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Md. | | 10b. County
Baltimore | | 10c. City, Town or Location
Timonium | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
2316 Wuthering Rd. | | | | 10f. Zip Code
21093 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WW-II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CPA | | | 16b. Kind of Business/Industry
State of Maryland | | |
| 17. Father's Name (First, Middle, Last)
Charles Constantine | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Anna Ponticos | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mrs. Estelle D. Constantine/wife | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2316 Wuthering Rd. Timonium, Md. 21093 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greek Orthodox Cemetery | | Date
6/4/99 | | 20c. Location - City or Town, State
Woodlawn, Md. | |
| 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
ANOXIC ENCEPHALOPATHY
a. Due to (or as a consequence of):
CARDIAC ARREST
b. Due to (or as a consequence of):
ARTERIOSCLEROTIC CARDIOVASCULAR
c. Due to (or as a consequence of):
DISEASE
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
8 DAYS
8 DAYS
YEARS | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
STATUS POST CORONARY ARTERY BYPASS GRAFTING-DISSEMINATED
INTRAVASCULAR COAGULATION WITH THROMBOSIS OF BYPASS
GRAFTS, ADRENAL VEINS; pulmonary infarcts | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. Place of Death (Check only one)
Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
PATHOLOGIST | | | | 29c. License number
D 14873 | | 29d. Date signed (Month, Day, Year)
5/31/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JAMES W. EAGAN, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 3 1999 | | 32. Registrar's Signature
 | | | | | | | |

Handwritten signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17728

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Oliver Council Jr.

2. Date of Death

MAY 30 1999

3. Time of Death

1245pm

4a. Facility Name (If not institution, give street and number)

Villa St. Michael Nsg. Retirement Ctr. Balto.

4b. City, Town, or Location of Death

Balto.

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

054-26-2552

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Jan. 15, 1924

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

2503 Violet Ave.

Apt.

509

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

Dept. of Water waste

17. Father's Name (First, Middle, Last)

Oliver Council Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Harriett Cross

19a. Informant's Name/Relationship (Type, Print)

Mrs. Helen Council (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2503 Violet Ave. Apt. 509 Balto. Md. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion

Date

4/5/99

20c. Location - City or Town, State

Lansdowne, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC COLON CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 MONTH

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Deborah I. Pierco

29c. License number

H45931

29d. Date signed (Month, Day, Year)

May 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deborah I. Pierco 7220 Park Heights Ave Baltimore MD 21208

31. Date filed (Month, Day, Year)

JUN 03 1999

32. Registrar's Signature

B. Sparks

State
Registrar

OLIVER COUNCIL

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

A45

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17729

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RUTH DARLING

2. Date of Death

Month Day Year
May 29 1999

3. Time of Death

1844

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George

Funeral
Director

5. Social Security Number

214-28-4594

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 22, 1928

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

27 N. Twin Circle Way

10f. Zip Code

21227

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10College (1-4 or 5+)
016a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Office Clerk

16b. Kind of Business/Industry

Office Supplies

17. Father's Name (First, Middle, Last)

Franklin Carl Fox

18. Mother's Name (First, Middle, Maiden Surname)

Elnora Ruth Hamilton

19a. Informant's Name/Relationship (Type, Print)

John Darling, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15815 Deer Creek Court, Laurel, Maryland 20707

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Baltimore Washington Cr. 5/31/99

Date

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Road, Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a.

Due to (or as a consequence of):

Coronary artery disease

years

b.

Due to (or as a consequence of):

COPD

years

c.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

malnutrition

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Pritham S. Saini MD

29c. License number

D 28998

29d. Date signed (Month, Day, Year)

May 29 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRITHAM S. SAINI MD, 9101 Cherry Ln #211
Laurel MD 20707

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17730

| | | | | | | | | | |
|---|---|--------------------------|---|---|--|--|--|--|-----------------------------------|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Charles H. Weise Jr. | | | | 2. Date of Death
Month Day Year
May 29 1999 | | 3. Time of Death
11:18 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
1979 Freeland Rd | | | | 4b. City, Town, or Location of Death
Freeland | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
219-10-4042 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
74 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Nov. 3 1924 | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Md | 10b. County
Baltimore | 10c. City, Town or Location
Freeland | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
1979 Freeland Rd. | | | | 10f. Zip Code
21053 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
self-employed | | 16b. Kind of Business/Industry
building contractor | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Charles H. Weise Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Annabelle Norton | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Shirley A. Weise wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1979 Freeland Rd. Freeland, Md 21053 | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel-Beltie | | 20c. Location - City or Town, State
Forest Hill, Md | | 20d. Date
May 31 1999 | | |
| | 21. Signature of Funeral Service Licensee
Kerita J. Wells | | 22. Name and Address of Facility
Evans Funeral Chapel
2325 YORK Rd. Timonium, Md 21093 | | | | | | |
| Physician
/Medical
Examiner | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| | Immediate Cause (Final disease or condition resulting in death)
a. CEREBRAL HYPOXIA
Due to (or as a consequence of): | | | | | | | | |
| | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. SEVERE ANEMIA
Due to (or as a consequence of): | | | | | | | | |
| | c. END STAGE LEUKEMIA
Due to (or as a consequence of):
d. LUNG CANCER | | | | | | | | |
| Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
LUNG CANCER | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once. | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28e. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
Francesco Grasso MD | | | | 29c. License number
D-38363 | | 29d. Date signed (Month, Day, Year)
5/29/1999 | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
FRANCESCO GRASSO MD 6569 NORTH CHARLES ST, TOWSON MD 21204 | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | | 32. Registrar's Signature
Genevieve B. Sparks | | | | |

99 1773

DMMH 16 Rev 6/95

**Physician
Medical
Examiner**

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17732

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LILLENE DAMRON

2. Date of Death
Month Day Year
JUNE 1, 1999

3. Time of Death
10:30 AM

4a. Facility Name (If not institution, give street and number)

1302 BURLINGHAM RD

4b. City, Town, or Location of Death

LUTHERVILLE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

402-30-2828

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

OCT 19, 1924

9. Birthplace (State or Foreign Country)

KENTUCKY

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

LUTHERVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1302 BURLINGHAM RD

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

AT HOME

17. Father's Name (First, Middle, Last)

CHARLEY COLEMAN

18. Mother's Name (First, Middle, Maiden Surname)

BERTHA COLEMAN

19a. Informant's Name/Relationship (Type, Print)

JOHN L. DAMRON, SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1302 BURLINGHAM RD. LUTHERVILLE, MD. 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DOLANEY VALLEY MEM. GDN.

Date

JUNE 5, 1999

20c. Location - City or Town, State

TIMONIUM, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EVANS CHAPEL OF CHIMES
2325 YORK RD. TIMONIUM, MD. 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic cardiovascular disease 10 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. myocardial infarction immediate

Due to (or as a consequence of):

c. atrial fibrillation 6 yrs

Due to (or as a consequence of):

d. Cerebral Stroke 15 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George T. Gilmore MD

29c. License number

D02325

29d. Date signed (Month, Day, Year)

6/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEORGE T. GILMORE, MD. 12221-3 TULLUMORE RD BALTIMORE, MD.

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

George T. Gilmore

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17733

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph L. EDWARDS SR.

2. Date of Death

Month Day Year
MAY 27 1999

3. Time of Death

1717

4a. Facility Name (If not institution, give street and number)

SINAI Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

250-30-6443

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71 72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 26
08 13 27

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4112 Penhurst Ave

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

1 yr

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Pipe Fitter

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

Sylvester Edwards

18. Mother's Name (First, Middle, Maiden Surname)

Rose Cabbage Stalk

19a. Informant's Name/Relationship (Type, Print)

Joseph Edwards Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4112 Penhurst Ave, Baltimore Md 21215

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Vet

Date

6/3/99

20c. Location - City or Town, State

Owings Mills, Md

21. Signature of Funeral Service Licensee

Shannon Stokes

22. Name and Address of Facility

March F/H
4300 Wabash Ave, Baltimore Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Arrest

Approximate Interval Between Onset and Death

Unknown

b. Due to (or as a consequence of):

Severe COPD

Years

c. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Steven K. Dotte

29c. License number

D25379

29d. Date signed (Month, Day, Year)

5-27-99

30. Name and address of person who completed cause of death (from 23a) (Type, Print)

Steven K. Dotte Sinai Hospital of Baltimore

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

Benjamin B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

THE UNIVERSITY OF CHICAGO

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17734

| | | | | | | | | |
|---|--|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
FRANK FARRELL | | | | 2. Date of Death
Month 6 Day 2 Year 1999 | | 3. Time of Death
1:50 AM | |
| | 4a. Facility Name (If not institution, give street and number)
LOCH RAVEN CENTER - GENESIS ELDERCARE | | | | 4b. City, Town, or Location of Death
PARKVILLE | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
214-01-2866 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
88 Yrs. | | 8. Date of Birth (Month, Day, Year)
10-13-10 | |
| | 9. Birthplace (State or Foreign Country)
MASS. | | 10a. State
MARYLAND | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALTIMORE | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
4407 WILKENS AVENUE | | 10f. Zip Code
21229 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12TH GRADE
Collage (1-4or 5+) COLLEGE | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MACHINIST | | 16b. Kind of Business/Industry
INDUSTRIAL | | | | |
| 17. Father's Name (First, Middle, Last)
UNKNOWN | | | | 18. Mother's Name (First, Middle, Maiden Summa)
UNKNOWN | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
DONALD MACKEY (FRIEND) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4407 WILKENS AVENUE-BALTIMORE, MARYLAND 21229 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MORELAND MEMORIAL PARK | | 20c. Date
6/4/99 | | 20d. Location - City or Town, State
PARKVILLE, MARYLAND | | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
HUBBARD FUNERAL HOME, INC.
4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Pneumonia
Due to (or as a consequence of):
b. Chronic Obstructive Lung Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dementia | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | | |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
D 41901 | | 29d. Date signed (Month, Day, Year)
6-2-99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
3007 E Northern Parkway, Baltimore, MD 21214 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

A43

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17735

| | | | | | | | | | | | |
|---|--|---|---|---|--|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
SALLIE FREEMAN | | | | 2. Date of Death
Month MAY Day 30 Year 99 | | | | 3. Time of Death
12:25 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
ANNE ARUNDEL GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death
ANNAPOLIS | | | | 4c. County of Death
ANNE ARUNDEL | | |
| Funeral
Director | 5. Social Security Number
216-20-2670 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
76 Yrs. | | 8. Date of Birth (Month, Day, Year)
11-22-22 | | 9. Birthplace (State or Foreign Country)
SC. | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
MD. | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
CROWNSVILLE | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
1305 SUNRIZE BEACH RD. | | | | 10f. Zip Code
21032 | | | | 10g. Citizen of What Country?
U.S.A. | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
RETIRED TEACHER | | | | 16b. Kind of Business/Industry
BALTIMORE CITY | | | |
| 17. Father's Name (First, Middle, Last)
WILLIE KITCHEN | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ESSIE KITCHEN | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
CAROLYN PAYNE | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1305 SUNRIZE BEACH RD. CROWNSVILLE, MD. 21032 | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARBUTUS MEM. PARK | | | 20c. Location - City or Town, State
6-3-99 ARBUTUS MARYLAND | | | | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | | 22. Name and Address of Facility
ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PLACE BALTIMORE MARYLAND 21207 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. Cardiopulmonary arrest
Due to (or as a consequence of):</p> <p>b. Pleural effusion
Due to (or as a consequence of):</p> <p>c. Overwhelming infection
Due to (or as a consequence of):</p> <p>d. Type II Diabetes mellitus</p> </div> </div> | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier
[Signature] M.D. | | | | 29c. License number
00051437 | | 29d. Date signed (Month, Day, Year)
5/30/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
OKEDWD DARCY BITOYE 21401
ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS MD | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 03 1999 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

4416

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17736

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marie R. Francis

2. Date of Death

Month
May

Day

29,

Year

1999

3. Time of Death

8:35 PM

4a. Facility Name (If not Institution, give street and number)

Franklin Woods Nursing Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

217-12-9945

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
May 25, 1903

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1315 Chesaco Avenue

10f. Zip Code

21237

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

3rd Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

Clothing Store

17. Father's Name (First, Middle, Last)

Guy Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Stapleton

19a. Informant's Name/Relationship (Type, Print)

Mr. Bernard Dukes (cousin)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

201 Yorkshire Way, Bel Air, MD 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Sacred Heart of Jesus

Date

6/2/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

► Brian A. Wilkin

22. Name and Address of Facility

Schimunek Funeral Home, Inc.
9705 Belair Rd., Baltimore, MD 2123623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. pneumonia
Due to (or as a consequence of):b. Aspiration
Due to (or as a consequence of):c. Hyperthyroidism
Due to (or as a consequence of):d. Hypertension
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Severe osteoporosis

H/o frequent falls, compression fx, cataracts

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be
3 ☐ Suicide 4 ☐ Homicide determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

► Sohail Mustafa Darni, MD

29c. License number

D-48025

29d. Date signed (Month, Day, Year)

5/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sohail Mustafa Darni, MD 1224 Chesaco Ave 21237

State
Registrar

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17737

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edward J. Furman

2. Date of Death

Month Day Year
MAY 26 1999

3. Time of Death

11:52 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

212-05-7775

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)
September 4, 1915

9. Birthplace (State or Foreign Country)

Baltimore City, Md.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

15 A Arlen Road

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)
N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Wholesale Liquor Salesman

16b. Kind of Business/Industry

Kronheim Co.

17. Father's Name (First, Middle, Last)

Stephen Furman

18. Mother's Name (First, Middle, Maiden Surname)

Mary Anna Unknown

19a. Informant's Name/Relationship (Type, Print)

Mary Alice Furman (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

38 Laurel Path Court Baltimore, Maryland 21236

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Gdns. June 1, 1999

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Robert Joseph Chinnick

22. Name and Address of Facility

Lassahn Funeral Home, Inc.

7401 Belair Road Baltimore, Maryland 21236-4625

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

MI

Due to (or as a consequence of):

Cardiopulmonary Arrest

Approximate Interval Between Onset and Death

Days

Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e.

b.

c.

d.

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24e. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural

☐ Accident

☐ Suicide

☐ Homicide

☐ Pending investigation

☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician

☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael A. Sparks

29c. License number

D52279

29d. Date signed (Month, Day, Year)

5/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SRIRAM H. BALASUBRAMANIAN

333 Quilting Way, Bel Air, MD

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

Michael A. Sparks

State
Registrar

FURMAN, EDWARD J.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17738

| | | | | | | | | | | |
|---|--|-------------|---|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ROBERT K. FORD SR. | | | | 2. Date of Death
Month Day Year
JUNE 01, 1999 | | 3. Time of Death
2:10 PM. | | | |
| | 4a. Facility Name (If not institution, give street and number)
1143 E. PATAPSCO AVE. | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death | | | |
| Funeral
Director | 5. Social Security Number
220.38.8607 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
56 Yrs. | | 8. Date of Birth (Month, Day, Year)
OCTOBER 24, 1942 | | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MARYLAND | | 10b. County | | 10c. City, Town or Location
BALTIMORE | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number
1143 E. PATAPSCO AVE. | | | | 10f. Zip Code
21225 | | 10g. Citizen of What Country?
UNITED STATES | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
APPRENTICE PLUMBER | | | 16b. Kind of Business/Industry
GRAMULK CO. | | | |
| 17. Father's Name (First, Middle, Last)
STANLEY FORD | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
VIOLET E. EBERLE | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
PHYLLIS A. HEVERLING SISTER | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8370 ELM RD. MILLERSVILLE, MD 21108 | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematorium, or other place)
METRO CREMATORY INC | | Date
21 JUNE 1999 | | 20c. Location - City or Town, State
BALTIMORE, MD | | | |
| 21. Signature of Funeral Service Licensee
K. GREGORY FINK | | | | | 22. Name and Address of Facility
FINK FUNERAL HOME, P.A.
426 CRAIN HWY. SW. GLEN BURNIE, MD. 21061 | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <u>Atherosclerotic Cardiovascular Disease</u>
Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. _____ Due to (or as a consequence of):
c. _____ Due to (or as a consequence of):
d. _____ | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Chronic Obstructive Pulmonary Disease</u>
<u>Chronic Alcoholism</u> | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
Dennis J. Chute, MD | | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
JUNE 02, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 3 1999 | | | 32. Registrar's Signature
B. Sparks | | | | | | | |

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17739

| | | | | | | | | | | |
|--|---|-------------|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GORDON J. FOSTER, JR. | | | | | | 2. Date of Death
Month Day Year
MAY 27, 1999 | | 3. Time of Death
12:11 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
535 FREEMAN STREET | | | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
213-36-1982 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
59 Yrs. | | 8. Date of Birth (Month, Day, Year)
8/11/1939 | | 9. Birthplace (State or Foreign Country)
BALTIMORE, MD | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County | | 10c. City, Town or Location
BALTIMORE | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
535 FREEMAN STREET | | | | 10f. Zip Code
21225 | | 10g. Citizen of What Country?
U.S.A. | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1954-9 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MACHINE OPERATOR | | | 16b. Kind of Business/Industry
W.R. GRACE | | | |
| 17. Father's Name (First, Middle, Last)
GORDON J. FOSTER, SR. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
EILEEN L. PUTNAM | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
CECILIA A. FOSTER - WIFE | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
535 FREEMAN ST., BALTIMORE, MD 21225 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
CEDAR HILL CEMETERY | | Date
6/1 | | 20c. Location - City or Town, State
BALTIMORE, MD | | |
| 21. Signature of Funeral Service Licensee

KELLY GREGORY FINK | | | | 22. Name and Address of Facility
FINK FUNERAL HOME, P.A.
426 CRAIN HWY., S.W., GLEN BURNIE, MD 21061 | | | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOPULMONARY ARREST
Due to (or as a consequence of):

b. ADENOCARCINOMA OF THE LUNG
Due to (or as a consequence of):

c. WITH LIVER AND BRAIN METASTASES
Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Dying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and Title of Certifier

STEPHEN IZZI, MD | | | | 29c. License number
D25782 | | 29d. Date signed (Month, Day, Year)
MAY 27, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
STEPHEN IZZI, MD 7575 RITCHIE HWY, GLEN BURNIE, MD 21060 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | | 32. Registrar's Signature
 | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

AH 10+1

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17740

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANDREW A. GALLIK

2. Date of Death

MAY 29th 1999

3. Time of Death

9:44 am.

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

185-18-2550

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 29, 1923

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

556 Brisbane Road

10f. Zip Code

21229

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates: 1943-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Warehouse Worker

16b. Kind of Business/Industry

Produce Company

17. Father's Name (First, Middle, Last)

Michael Thomas Gallik

18. Mother's Name (First, Middle, Maiden Surname)

Susanne (Unknown)

19a. Informant's Name/Relationship (Type, Print)

Dorothy R. Gallik/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

556 Brisbane Road Baltimore, Maryland 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery 6/3/99 Owings Mills, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Juanita R. Thomas

22. Name and Address of Facility

Hubbard Funeral Home, Inc.
4107 Wilkens Avenue Baltimore, Maryland 21229

23a. Pertinent enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

PNEUMONIA

Approximate Interval Between Onset and Death

1 MONTH

e. Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE 2 MONTHS.

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Maghekar MD. HOUSESTAFF

29c. License number

P11949

29d. Date signed (Month, Day, Year)

MAY 29th 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ashay Maghekar, Harbor Hospital Center, 3001 South Hancock St, Baltimore, MD.

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Handwritten signature and date: *John A. Smith* DEC 1 1962

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17741

| | | | | | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|---|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Betty M. Gookool</u> | | | | 2. Date of Death
Month <u>5</u> Day <u>31</u> Year <u>99</u> | | 3. Time of Death
<u>12:36 AM</u> | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
<u>UNIVERSITY OF MARYLAND MEDICAL CENTER</u> | | | | 4b. City, Town, or Location of Death
<u>BALTIMORE</u> | | 4c. County of Death | | | | | | |
| Funeral
Director | 5. Social Security Number
<u>215-06-2982</u> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>63</u> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<u>MARCH 12 1936</u> | 9. Birthplace (State or Foreign Country)
<u>Trinidad</u> | | | | | |
| | Usual Residence of Decedent | | | | 10a. State
<u>Md</u> | | 10b. County | | | | | | |
| To Be Completed by Funeral Director | 10c. City, Town or Location
<u>Baltimore</u> | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
<u>2702 Fleetwood Ave</u> | | | | | | |
| | 10f. Zip Code
<u>21214</u> | | | | 10g. Citizen of What Country?
<u>Trinidad</u> | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | | | |
| | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>Black</u> | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>homemaker</u> | | 16b. Kind of Business/Industry
<u>home</u> | | | | | | |
| | 17. Father's Name (First, Middle, Last)
<u>Daniel Kalloo</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Lutchmin Sankaran</u> | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
<u>Samuel Gookool</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>2702 Fleetwood Ave. Baltimore, Md 21214</u> | | | | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Evans Funeral Chapel - Belair</u> | | 20c. Location - City or Town, State
<u>Forest Hill, Md</u> | | 20d. Date
<u>June 3 1999</u> | | | | | | |
| | 21. Signature of Funeral Service Licensee
<u>Keista S. Wells</u> | | | | 22. Name and Address of Facility
<u>Evans Funeral Chapel</u>
<u>8800 Harford Rd. Baltimore, Md 21234</u> | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. <u>Exsanguination</u>
Due to (or as a consequence of):</td> <td rowspan="4"> Approximate Interval Between Onset and Death

 <u>12 hrs</u> </td> </tr> <tr> <td>b. <u>Aortic dissection</u>
Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____
Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____
Due to (or as a consequence of):</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <u>Exsanguination</u>
Due to (or as a consequence of): | Approximate Interval Between Onset and Death

<u>12 hrs</u> | b. <u>Aortic dissection</u>
Due to (or as a consequence of): | c. _____
Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <u>Exsanguination</u>
Due to (or as a consequence of): | Approximate Interval Between Onset and Death

<u>12 hrs</u> | | | | | | | | | | | |
| | b. <u>Aortic dissection</u>
Due to (or as a consequence of): | | | | | | | | | | | | |
| | c. _____
Due to (or as a consequence of): | | | | | | | | | | | | |
| | d. _____
Due to (or as a consequence of): | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Hypertension</u> | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<u>M</u> | | 28c. Injury et Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<u>Bret D. Borchelt</u> | | 29c. License number
<u>D44498</u> | | 29d. Date signed (Month, Day, Year)
<u>5/31/99</u> | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<u>BRET D. BORCHELT, MD 22 S. GREENE ST, BALTIMORE, MD 21201</u> | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<u>JUN 3 1999</u> | | 32. Registrar's Signature
<u>Bret D. Borchelt</u> | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

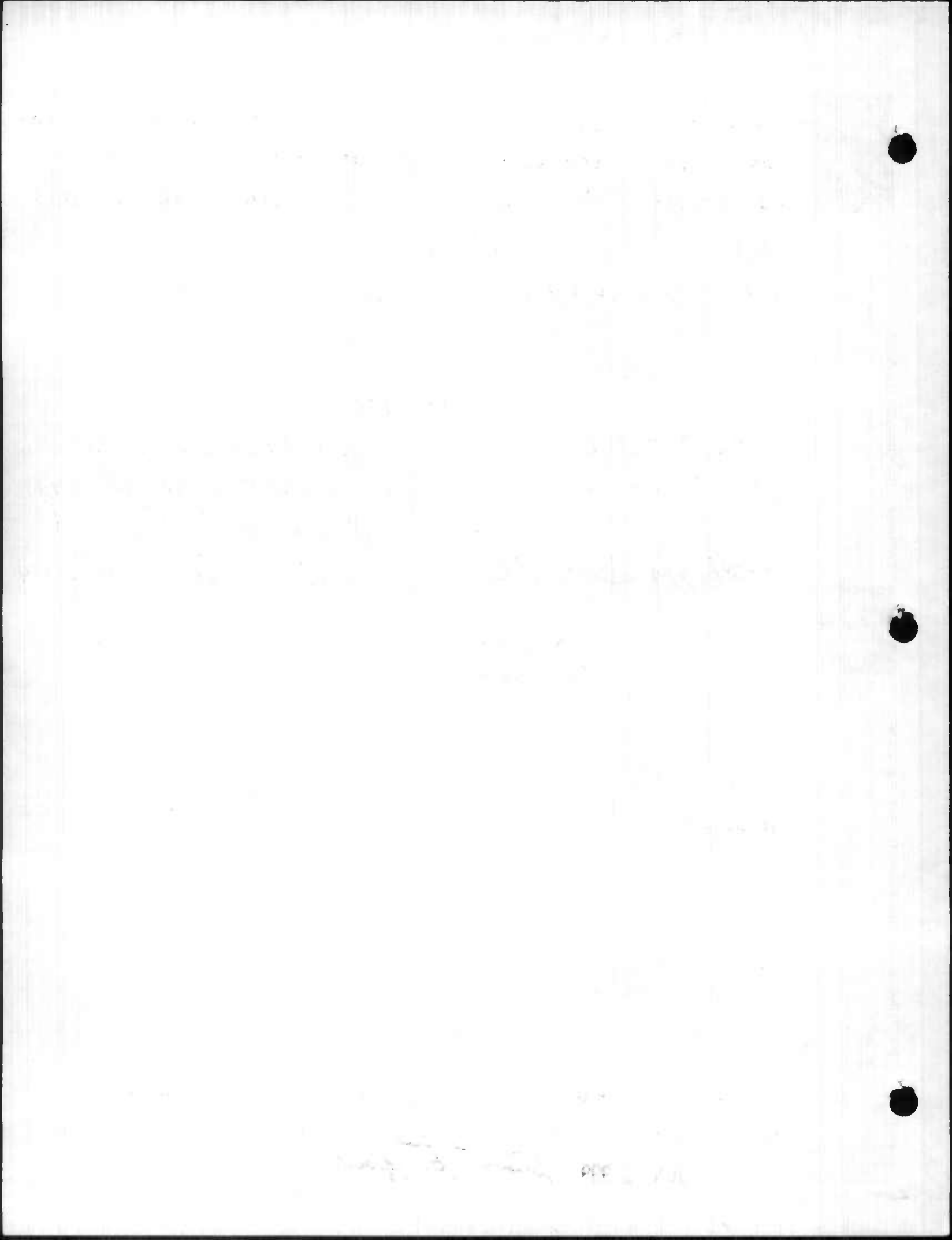
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17742

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--------------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BAROND J. GOODHUES, Jr. | | | | 2. Date of Death
Month Day Year
May 31, 1999 | | 3. Time of Death
4:00 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
Stella Maris Hospice | | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
219-28-7810 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
67 Yrs. | | 8. Date of Birth (Month, Day, Year)
Aug. 15, 1931 | | |
| | 9. Birthplace (State or Foreign Country)
Md. | | 10a. State
Md. | | 10b. County
Baltimore | | 10c. City, Town or Location
Perry Hall | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
2J Brook Farm Ct. | | 10f. Zip Code
21128 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: Korea | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Self Employed | | 16b. Kind of Business/Industry
Dutch Mill Lounge | | | | | |
| 17. Father's Name (First, Middle, Last)
Barond J. Goodhues, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname)
Althea M. Bankerd | | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Barbara A. Goodhues/wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2J Brook Farm Ct. Perry Hall, Md. 21128 | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Memorial | | 20c. Date
6/3/99 | | 20d. Location - City or Town, State
Timonium, Md. | | | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, MD. 21204 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | a. Chronic Obstructive Pulmonary Disease
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. | | Approximate Interval Between Onset and Death | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
[Signature] | | 29c. License number
D43725 | | 29d. Date signed (Month, Day, Year)
6/11/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093 | | 31. Date filed (Month, Day, Year)
JUN - 3 1999 | | 32. Registrar's Signature
[Signature] | | | | | |

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17743

| | | | | | | | | |
|--|---|-----------------------------------|---|--------------------------------------|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOSEPHINE GROCHOWSKI | | | | 2. Date of Death
Month Day Year
MAY 31 1999 | | 3. Time of Death
1:32 PM | |
| | 4a. Facility Name (If not institution, give street and number)
CHURCH HOME | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/a | |
| Funeral
Director | 5. Social Security Number
215-54-0966 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
93 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 17, 1905 | |
| | 9. Birthplace (State or Foreign Country)
Poland | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Lutherville | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
1302 Macphersons Ct. | | | | 10f. Zip Code
21093 | | 10g. Citizen of What Country?
U. S. A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6th Grade | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | |
| | 17. Father's Name (First, Middle, Last)
John Kucinski | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Anna Gutowski | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Dolores McClean (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1302 Macphersons Ct., Lutherville, Maryland 21093 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Stanislaus | | Data
5/3/99 | | 20c. Location - City or Town, State
Baltimore, Maryland | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Schumnek Funeral Home Inc.
3331 Brehms Lane, Baltimore, Maryland 21213 | | | |
| | 23a. Part I: Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ASCVD
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Approximate Interval Between Onset and Death
years | | | | | | | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Renal Failure | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D16619 | | 29d. Date signed (Month, Day, Year)
June 2, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
C. VERGARA-SOARES 101 N. BOND ST. BALTIMORE, MD. 21231 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | 32. Registrar's Signature
 | | | | | | |
| State Registrar | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 177111

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Melvin Charles Gill

2. Date of Death

Month May 30 Day 1999 Year

3. Time of Death

8:45 P.M.

4a. Facility Name (If not institution, give street and number)

116 Bliss Lane

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

217-24-4443

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 11, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

116 Bliss Lane

10f. Zip Code

21060

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces? 1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 195213. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Foreman Mechanic

16b. Kind of Business/Industry

Steel

17. Father's Name (First, Middle, Last)

George Gill

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Sherman

19a. Informant's Name/Relationship (Type, Print)

Loretta R. Gill/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

116 Bliss Lane Glen Burnie, MD 21060

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory

Date

June 3, 1999

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Kirkley-Ruddick Funeral Home P.A.

421 Crain Hwy. S.E. Glen Burnie, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. AdenoCarcinoma Lung
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

3 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. _____
Due to (or as a consequence of):c. _____
Due to (or as a consequence of):d. _____
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

047137

29d. Date signed (Month, Day, Year)

June, 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter P. Ramirez M.D. 7845 Oakwood Road Glen Burnie, Md 21061 Suite 201

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

P. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-358-0000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

1000 2000 3000 4000 5000 6000 7000 8000 9000 10000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17745

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Rosemary C. Gregory
2. Date of Death Month Day Year MAY 27 1999
3. Time of Death 11:05 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death TOWSON
4c. County of Death BALTIMORE
5. Social Security Number 438-24-4911
6. Sex 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday) 75 Yrs.
8. Date of Birth (Month, Day, Year) 8-31-1923
9. Birthplace (State or Foreign Country) Louisiana

To Be Completed by Funeral Director

Usual Residence of Decedent
10a. State Maryland
10b. County Baltimore
10c. City, Town or Location Lutherville
10d. Inside City Limits 1 ☐ Yes 2 ☒ No
10e. Street and Number 8719 Valleyfield Road
10f. Zip Code 21093
10g. Citizen of What Country? U. S. A.
11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Homemaker
16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Own Home
16b. Kind of Business/Industry
17. Father's Name (First, Middle, Last) Leon Torregrossa
18. Mother's Name (First, Middle, Maiden Surname) Cecile Fortier
19a. Informant's Name/Relationship (Type, Print) Mr. Francis C. Gregory (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8719 Valleyfield Road, Lutherville, Maryland 21093
20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gards. 6-1-99 Timonium, Maryland
21. Signature of Funeral Service Licensee
22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204

Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death) e. CEREBRAL VASCULAR ACCIDENT
Due to (or as a consequence of):
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { b. ATRIAL FIBRILLATION
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number 053430
29d. Date signed (Month, Day, Year) MAY 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRED CHAM 6701 NORTH CHARLES STREET BALTIMORE MARYLAND 21204

State
Registrar

31. Date filed (Month, Day, Year) JUN - 3 1999
32. Registrar's Signature

Gregory, Rosemary

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, 2

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 177166

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JEREMIAH ALEXANDER GILBERT JR.

2. Date of Death
Month Day Year
May 31, 19993. Time of Death
10:00 PMFuneral
Director

4a. Facility Name (If not institution, give street and number)

VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death

PERRY POINT

4c. County of Death

CECIL

5. Social Security Number

717-09-7873

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUL 12 1919

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

HARFORD

10c. City, Town or Location

JOPPA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

425A DEMBYTOWN ROAD

10f. Zip Code

21085

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 44/45

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

CONSTRUCTION

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

JEREMIAH A GILBERT SR.

18. Mother's Name (First, Middle, Maiden Surname)

OSSIE GILBERT

19a. Informant's Name/Relationship (Type, Print)

Elsie e. Lingham/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

518 Dembytown Road, Joppa, Maryland 21085

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

EBENEZER BAPTIST CHURCH

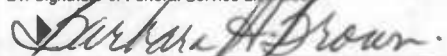
Date

6-5-99

20c. Location - City or Town, State

JOPPA, MARYLAND

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

WILLIAM C BROWN COMMUNITY FH-HARFORD, P.A.
321 S PHILADELPHIA BLVD ABERDEEN, MD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 WEEKS

b. MULTIPLE CEREBROVASCULAR ACCIDENTS

Due to (or as a consequence of):

3 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D20215

29d. Date signed (Month, Day, Year)

May 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KARMACHANDRA NAIR, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND

31. Date filed (Month, Day, Year)

JUN - 3 1999

32. Registrar's Signature

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

NAME KNOWN TO PHYSICIAN: GILBERT, JEREMIAH

Baltimore, Maryland 21215-0020

A44

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17747

MARION FRANCIS HUFF

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | | | |
|---|--|---|--|--|---|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last)
Marion Francis Huff | | | | | | 2. Date of Death
Month 5 Day 14 Year 99 | | 3. Time of Death
10:50 am | |
| 4a. Facility Name (If not institution, give street and number)
29502 Nancy Street | | | | 4b. City, Town, or Location of Death
Easton | | 4c. County of Death
Talbot | | | |
| 5. Social Security Number
307-42-9873 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
54 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
June 24, 1945 | | 9. Birthplace (State or Foreign Country)
Kentucky | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
Talbot | | 10c. City, Town or Location
Easton | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
29502 Nancy Street | | | | 10f. Zip Code
21601 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Estate Manager | | | 16b. Kind of Business/Industry
Caretaker | | |
| 17. Father's Name (First, Middle, Last)
Ollie James Huff | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Elma Gentry | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Cheri Huff/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
29502 Nancy Street, Easton, Maryland 21601 | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Washington Cr. | | Date
5/21/99 | | 20c. Location - City or Town, State
Laurel, Maryland | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Fleck Funeral Home, Inc.
7601 Sandy Spring Road, Laurel, Maryland 20707 | | | | | |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Pancreatic carcinoma | | | | | | | | Approximate Interval Between Onset and Death
3M | |
| Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of): | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D32036 | | 29d. Date signed (Month, Day, Year)
5/14/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gary J. Sprave 2108 N. Darrach Drive Chelster, MD 21619 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | | 32. Registrar's Signature
 | | | | | |

State
Registrar

AD 641

| | | | | | | | | |
|-----------------------------------|---|---|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Jesse Craig Henderson | | | | 2. Date of Death
Month MAY Day 22 Year 1999 | | 3. Time of Death
2:43 A | |
| | 4a. Facility Name (If not institution, give street and number)
108 N. STRICKER ST. | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
218-74-7879 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
40 Yrs. | | 8. Date of Birth (Month, Day, Year)
MAR. 26, 1959 | |
| | Usual Residence of Decedent | | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| | | | | | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | | 10e. Street and Number
1027 Hollins St. | | 10f. Zip Code
21223 | | 10g. Citizen of What Country?
USA | | |
| | | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: black |
| | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Maintenance/Truck Driver | | 16b. Kind of Business/Industry
Trucking | | |
| | | 17. Father's Name (First, Middle, Last)
(Unavailable) Henderson | | 18. Mother's Name (First, Middle, Maiden Surname)
Arlethea Robertson | | | | |
| | | 19a. Informant's Name/Relationship (Type, Print)
Harbor City Unlimited | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1 N. Carey St., Balto., Md. 21223 | | | | |
| | | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Mem. Park | | Date
6/03/99 | | 20c. Location - City or Town, State
Elkridge, Md. |
| | | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc
7250 Washington Blvd., Elkridge, Md. 21075 | | | | |
| | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Narcotic intoxication
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | |
| | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | |
| | | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
5-22-99 | | 28b. Time of Injury
Unk. M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
House | | 28d. Describe how injury occurred
Unknown | | |
| | | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
House | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
108 N. Stricker St., Baltimore, | | |
| | | 29a. Certifier
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MD
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | |
| | | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
MAY 22, 1999 | | |
| | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jesse Craig Henderson
111 Penn Street, Baltimore, Maryland 21201 | | | | | | |
| | | 31. Date filed (Month, Day, Year)
JUN 3 1999 | | 32. Registrar's Signature
 | | | | |
| State Registrar | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17749

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
DESMOND MICHAEL HEUBECK | | | | 2. Date of Death
Month Day Year
MAY 30 1999 | | 3. Time of Death
7:35 AM | |
| 4a. Facility Name (If not institution, give street and number)
NORTHWEST HOSPITAL | | | | 4b. City, Town, or Location of Death
RANDALLS TOWN | | 4c. County of Death
BALTIMORE | |
| 5. Social Security Number
213-42-4406 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
54 | | 8. Date of Birth (Month, Day, Year)
July 2, 1944 | |
| 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
4022 Falls Road | | 10f. Zip Code
21211 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1961-64 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Clerk for Circuit Court | | 16b. Kind of Business/Industry
Baltimore City | | 17. Father's Name (First, Middle, Last)
Alvin Lee Heubeck | |
| 18. Mother's Name (First, Middle, Maiden Summa)
Zelma Mae Mitchell | | 19a. Informant's Name/Relationship (Type, Print)
Tom Heubeck Nephew | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13823 Ansari Lane, Baldwin, Maryland 21013 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans Cemetery 6/4/99 Garrison Forest, MD | | 21. Signature of Funeral Service Licensee
Burpee-Henss-Seitz Funeral Home, Inc. 21211 | | 22. Name and Address of Facility
3631 Falls Road, Baltimore, Maryland | | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Michael Rothen MD | |
| 29c. License number
D43401 | | 29d. Date signed (Month, Day, Year)
MAY 30, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
5401 OLD COURT ROAD RANDALLS TOWN, MARYLAND 21133 | | 31. Date filed (Month, Day, Year)
JUN 03 1999 | |
| 32. Registrar's Signature
B. Sparks | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

VOID
CERTIFICATE #

12750

SEE

CERTIFICATE #

STAMP OVER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17751

| | | | | | | | | | | |
|--|---|--|--|--|--|---|--|---|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CARL JOHN HELLMAN | | | | | 2. Date of Death
Month Day Year
MAY 30 1999 | | | 3. Time of Death
3:15 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
HARFORD MEMORIAL HOSPITAL | | | | | 4b. City, Town, or Location of Death
HARFORD | | | 4c. County of Death
HARFORD | |
| Funeral
Director | 5. Social Security Number
215-16-7467 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
76 Yrs. | | 8. Date of Birth (Month, Day, Year)
OCT. 29 1922 | | 9. Birthplace (State or Foreign Country)
WASHINGTON D.C. | |
| | Usual Residence of Decedent | | | | | 10a. State
MARYLAND | | 10b. County
HARFORD | | 10c. City, Town or Location
FOREST HILL |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 10e. Street and Number
1702 RICHWAY 1B | | | 10f. Zip Code
21050 | |
| | 10g. Citizen of What Country?
U.S.A. | | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WW II | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 YRS. College (1-4 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SELF EMP. - OWNER | | | | | 16b. Kind of Business/Industry
RESTAURANT | | | 17. Father's Name (First, Middle, Last)
KARL J. HELLMAN | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
ANNA M. MOHR | | | | | 19a. Informant's Name/Relationship (Type, Print)
DONNA L. HELLMAN | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1702 RICHWAY 1B FOREST HILL, MARYLAND 21050 | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HIGHVIEW MEMORIAL GARDENS | | | 20c. Location - City or Town, State
FALLSTON MARYLAND | |
| | 21. Signature of Funeral Service Licensee
[Signature] | | | | | 22. Name and Address of Facility
EVANS FUNERAL CHAPEL - BELAIR, P.A.
3 NEWPORT DRIVE FOREST HILL, MARYLAND 21050 | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediata Causa (Final disease or condition resulting in death)
a. Acute renal failure
Due to (or as a consequence of):
b. Anorexia
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

few days
few months | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day Year) | | | | | 28b. Time of Injury
M | | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | |
| 29b. Signature and title of certifier
Claudia A. Kroker MD | | | | | 29c. License number
D50040 | | | 29d. Date signed (Month, Day, Year)
MAY 30 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. CLAUDIA A. A. KROKER 1308 BUSINESS CENTER WAY | | | | | 31. Data filed (Month, Day, Year)
JUN 3 1999 | | | 32. Registrar's Signature
[Signature] | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at office.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar

[Faint, illegible handwritten text]

1000 11/11/11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17752

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FREDERICK H. HEUSI

2. Date of Death

MAY 27 1999

Day

3. Time of Death

09:10 AM

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

213-03-3285

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

May 26, 1915

9. Birthplace (State or Foreign Country)

Baltimore, Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore Co.

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8415 Bellona Lane Apt. 1010

10f. Zip Code

21204

10g. Citizen of What Country?

United States of America

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No W.W.II
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Stereotype Setter

16b. Kind of Business/Industry

Baltimore Sun Paper

17. Father's Name (First, Middle, Last)

John Henry Heusi

18. Mother's Name (First, Middle, Maiden Surname)

Florence M. Blaney

19a. Informant's Name/Relationship (Type, Print)

Mr. John J. Damaby(Cousin)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1602 Dunwich Garth Lutherville, Maryland 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Memorial Park

Date

5/29/1999

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee Jeffrey L. Gair

22. Name and Address of Facility Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Maryland 21204

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. multi-system failure
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 days

b. INVASIVE necrotic bladder cancer
Due to (or as a consequence of):

2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. anemia
Due to (or as a consequence of):

2 years

d. chronic gross hematuria
Due to (or as a consequence of):

2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Joseph A Bess Jr MD Surgical Intern

29c. License number

AT2438946.N33

29d. Date signed (Month, Day, Year)

MAY 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH A BESS JR Union Memorial Hospital UNIVERSITY PARKWAY BALTIMORE, MD

31. Date filed (Month, Day, Year)

JUN - 3 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17753

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Arthur G. Hall, Jr.

2. Date of Death

May 29, 1999

3. Time of Death

11:40 PM

4a. Facility Name (If not institution, give street and number)

St. Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore Co.

Funeral
Director

5. Social Security Number

219-22-1307

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 03, 1926

9. Birthplace (State or Foreign Country)

Baltimore, Md.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore Co.

10c. City, Town or Location

Lutherville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

400 Rockfleet Road

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: W.W.II

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

02

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Mack Truck Co.

17. Father's Name (First, Middle, Last)

Arthur G. Hall, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Gola Lawson

19a. Informant's Name/Relationship (Type, Print) (Wife)

Mrs. Sara K. (nee Kennedy) Hall

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

400 Rockfleet Road Lutherville, Maryland 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Dulaney Valley Mem. Gard. 6/03/1999 Timonium, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Michael J. Smith

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. Atherosclerosis

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 hr

3+

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Squamous Cell Lung

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Arthur A. Serpico MD

29c. License number

D10091

29d. Date signed (Month, Day, Year)

6/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arthur A. Serpico MD St. Joe Med Ctr Towson, MD 21204

State
Registrar

31. Date filed (Month, Day, Year)

JUN - 3 1999

32. Registrar's Signature

Jennifer B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17754

| | | | | | | | | |
|---|--|--|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EDITH HARRISON | | | | 2. Date of Death
Month 5 Day 27 Year 99 | | 3. Time of Death
5:20 PM | |
| | 4a. Facility Name (If not institution, give street and number)
FUTURE CARE CHERRYWOOD NURSING HOME | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
OWINGS MILLS MARYLAND | |
| Funeral
Director | 5. Social Security Number
220-03-9806 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (in yrs. last birthday)
85 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept 27, 1913 | |
| | 9. Birthplace (State or Foreign Country)
VA | | | | | | | |
| To Be Completed by Funeral Director | 10e. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Reisters town, MD | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
32 Brookbury Drive Apt. 1D | | | | 10f. Zip Code
21136 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4th College (14or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Grocery Store Owner | | 16b. Kind of Business/Industry
Market | | | |
| | 17. Father's Name (First, Middle, Last)
James Clark | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Alice Clark | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Mary Miller / Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
32 Brookbury Dr. Apt. 1D Balto, MD 21136 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery | | 20c. Date
6/2/99 | | 20d. Location - City or Town, State
Baltimore, MD | |
| | 21. Signature of Funeral Service Licensee
James F. Tharch | | | | 22. Name and Address of Facility
Gary P. March Funeral Home PA
370 Fredrickton Pass Baltimore, MD 21227 | | | |
| | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div> <p>a. Delayed Cerebrovascular Accident
Due to (or as a consequence of):</p> <p>b. Chronic Atrial Fibrillation
Due to (or as a consequence of):</p> <p>c. Chronic Renal Failure from Hypertension
Due to (or as a consequence of):</p> <p>d. Coronary Heart Disease</p> </div> </div> | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Hay H. Myint - MD | | | | 29c. License number
D 47990 | | 29d. Date signed (Month, Day, Year)
6/01/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HTAY H. MYINT - MD
1838 GREENE TREE ROAD, SUITE 135, BALTIMORE, MD 21208 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | | 32. Registrar's Signature
Benjamin P. Sparks | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

DHMH 16 Rev 6/95

It is a matter of fact that

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17755

| | | | | | | | | |
|---|---|--|---|--|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
TYRELL S. HURT | | | | 2. Date of Death
Month Day Year
MAY 29, 1999 | | 3. Time of Death
0222 | |
| | 4a. Facility Name (If not institution, give street and number)
3 WARFIELD ROAD | | | | 4b. City, Town, or Location of Death
GLEN BURNIE | | 4c. County of Death
ANNE ARUNDEL | |
| Funeral
Director | 5. Social Security Number
219.53.9495 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
Yrs. 4 | | 8. Date of Birth (Month, Day, Year)
01/20, 1999 | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MD | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
GLEN BURNIE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
3 WARFIELD ROAD | | 10f. Zip Code
21061 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 0 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
NEVER WORKED | | 16b. Kind of Business/Industry | | | |
| | 17. Father's Name (First, Middle, Last)
TYRONE HURT | | | | 18. Mother's Name (First, Middle, Maiden Surname)
LACHER V. MASON | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
LACHER V. MASON - MOTHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3 WARFIELD ROAD, GLEN BURNIE, MD 21061 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HOLY CROSS CEMETERY | | 20c. Location - City or Town, State
BALTIMORE, MD | | 20d. Date
6/5 | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee

KELLY GREGORY FINK | | | | 22. Name and Address of Facility
FINK FUNERAL HOME, PA
426 CRAIN HWY., SW, GLEN BURNIE, MD 21061 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
BRAIN TUMOR
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
4 months
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death
4 months |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier
 | | | | 29c. License number
174238L | | 29d. Date signed (Month, Day, Year)
JUNE 2, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
UNIVERSITY OF MD PEDIATRIC ONCOLOGY - 22 S. GREENE STREET, BALT. MD 21201 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17756

| | | | | | | | | | | | | | | | | | | | | | |
|--|---|--------------------------|---|--|--|--|--|---|---|----|--------------------------|--------|----|-------------------------|----------|----|--|--|----|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Mary Louise Hall | | | | 2. Date of Death
Month Day Year
June 1, 1999 | | 3. Time of Death
12:14 P.M. | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death
Rosedale | | 4c. County of Death
Baltimore | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
230-01-4554 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
78 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 15, 1921 | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country)
Virginia | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Middle River | | | | | | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | |
| 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| 10e. Street and Number
347 Endsleigh Avenue | | | | 10f. Zip Code
21220 | | 10g. Citizen of What Country?
U.S.A. | | | | | | | | | | | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
8 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | 16b. Kind of Business/Industry
Own Home | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
Joseph Kieser | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Eva Etheridge | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
John T. Hall III | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
347 Endsleigh Avenue, Baltimore, Maryland 21220 | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hill Mem. Gardens | | Date
6/4/99 | | 20c. Location - City or Town, State
Baltimore, Maryland | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
John W. Burkauskas | | | | 22. Name and Address of Facility
Bruzdinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td>VENTRICULAR FIBRILLATION</td> <td>1 HOUR</td> </tr> <tr> <td>b.</td> <td>CORONARY ARTERY DISEASE</td> <td>20 YEARS</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | VENTRICULAR FIBRILLATION | 1 HOUR | b. | CORONARY ARTERY DISEASE | 20 YEARS | c. | | | d. | | |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | VENTRICULAR FIBRILLATION | 1 HOUR | | | | | | | | | | | | | | | | | | |
| | b. | CORONARY ARTERY DISEASE | 20 YEARS | | | | | | | | | | | | | | | | | | |
| | c. | | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
LUNG CANCER | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 28. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | |
| | | | 28d. Describe how injury occurred | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
[Signature] | | | | 29c. License number
D22620 | | 29d. Date signed (Month, Day, Year)
June 02, 1999 | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Shahid Saeed, 9000 Franklin Square Drive, Baltimore, Maryland 21237 | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 03 1999 | | | 32. Registrar's Signature
[Signature] | | | | | | | | | | | | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17757

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Bobbie Lenora Jefferson - Chapman

2. Date of Death

05 -30 -1999

3. Time of Death

2 a.m.

4a. Facility Name (If not institution, give street and number)

4404 Pen Lucy Rd.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

219-52-2653

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

49

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

02-23-1950

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4404 Pen Lucy Rd.

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12 th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Word Mail Clerk

16b. Kind of Business/Industry

Advertising

17. Father's Name (First, Middle, Last)

Robert Washington

18. Mother's Name (First, Middle, Maiden Surname)

Irene Barbour

19a. Informant's Name/Relationship (Type, Print)

Lawrence Chapman (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4404 Pen Lucy Rd. Balto., Md. 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Mem. Park Cem

Date

6/03/99

20c. Location - City or Town, State

Arbutus, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Caple Funeral Service

5502 Winner Ave. Balto., Md. 21215

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Liver failure

Approximate Interval Between Onset and Death

1 month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

Hepatitis C virus infection

years

c.

Due to (or as a consequence of):

HIV infection

years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D38637

29d. Date signed (Month, Day, Year)

6/5/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David M. Mazur, UMMS/ETC, 16 S. Euter St, Baltimore MD 21201

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

State
Registrar

ORIGINAL

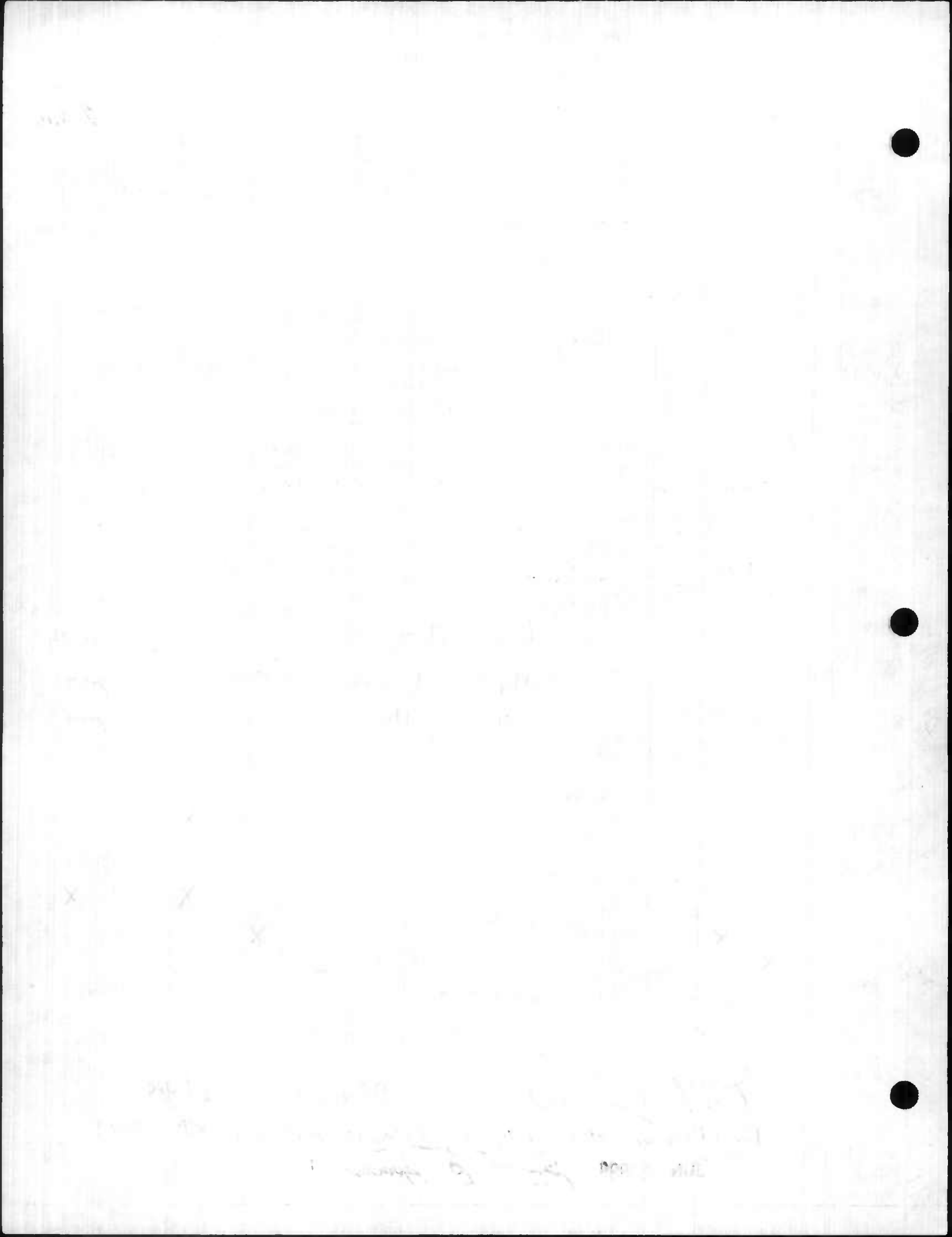
Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerDivision of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#8 PER F.H. G772 6-3-99 J.A.

Certificate of Death

Reg. No.

99 17758

| | | | | | | | | |
|---|--|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DORTHY JOHNSON | | | | 2. Date of Death
Month Day Year
5-23-99 | | 3. Time of Death
10:20 AM | |
| | 4a. Facility Name (If not institution, give street and number)
PIKESVILLE NURSING HOME | | | | 4b. City, Town, or Location of Death
PIKESVILLE | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
218-07-0660 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
90 Yrs. | | 8. Date of Birth (Month, Day, Year)
5-23-99 1909 | |
| | 9. Birthplace (State or Foreign Country)
VA. | | 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number
3337 GWYNNS FALLS PARKWAY | | 10f. Zip Code
21216 | |
| | 10g. Citizen of What Country?
U.S.A. | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: BALCK | | | | 14. Race - American Indian, Black, White, etc.
Specify: BALCK | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | | | 16b. Kind of Business/Industry
DOMESTIC | | 17. Father's Name (First, Middle, Last)
JOSEPH PURNELL | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Summa)
LILLIAN PORTER | | | | 19a. Informant's Name/Relationship (Type, Print)
JULIA L. PURNELL | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3337 GWYNNS FALLS PARKWAY BALTIMORE MARYLAND 21216 | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
DRUID RIDGE CEMETERY | | 20c. Location - City or Town, State
BALTIMORE, MARYLAND | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PLACE BALTIMORE MARYLAND 21217 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
end-stage CHF

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
ischemic cardiomyopathy
CAD | | | | Approximate Interval Between Onset and Death
months
years
years | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year)
May 23, 1999 | | | |
| To Be Completed by Physician/Medical Examiner | 28b. Time of Injury
M | | | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
 | | | |
| | 29c. License number
D37573 | | | | 29d. Date signed (Month, Day, Year)
May 28, 1999 | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jeff Zibell MD 7220 Park Heights Ave Baltimore MD 21208 | | | | 31. Data filed (Month, Day, Year)
JUN 03 1999 | | | |
| | 32. Registrar's Signature
 | | | | 33. State Registrar
MD | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17759

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY JONES

2. Date of Death

Month

Day

Year

MAY

26

1999

3. Time of Death

2:00

Am

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

217-22-0693

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

3-27-26

9. Birthplace (State or Foreign Country)

va.

Usual Residence of Decedent

10a. State

MD.

10b. County

BALTIMORE

10c. City, Town or Location

RANDALLSTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5524 OLD COURT RD.

10f. Zip Code

21244

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HUTZLERS

16b. Kind of Business/Industry

DEPARTMENT STORE

17. Father's Name (First, Middle, Last)

VAILES KNOX

18. Mother's Name (First, Middle, Maiden Surname)

NAOMI KNOX

19a. Informant's Name/Relationship (Type, Print)

WILLIAM JONES

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5524 OLD COURT RD. BALTIMORE MARYLAND 21244

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST CEMETERY

Date

6-1-99

20c. Location - City or Town, State

OWINSMILLS, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.

1300 EUTAW PLACE BALTIMORE, MARYLAND 21217

Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE CARDIOMYOPATHY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Few Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL FAILURE ON HEMODIALYSIS

DIABETIS MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 19502

29d. Date signed (Month, Day, Year)

MAY 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORLANDO B. COVATTA MD

NORTHWEST HOSPITAL CENTER

RANDALLSTOWN MD 21133

State
Registrar

31. Date filed (Month, Day, Year)

JUN 03 1999

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17760

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HILDA

2. Date of Death

JONES MAY 30 1999 5:49AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MANOR CARE NURSING HOME

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

219-07-2350

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs, last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

DEC. 17, 1914

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1946 W. FRANKLIN STREET

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
7th GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DAY CARE PROVIDER

16b. Kind of Business/Industry

SELF-EMPLOYED

17. Father's Name (First, Middle, Last)

GEORGE W. LANKFORD

18. Mother's Name (First, Middle, Maiden Surname)

ROSE WHITNEY

19a. Informant's Name/Relationship (Type, Print)

MARY MICKINGS (NIECE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

736 N. CARROLLTON AVE., BALTIMORE, MD. 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

VOSHILL MEM. GARDENS 06-4-99 BALTIMORE, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Person

[Signature]

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE., BALTO, MD. 21217

23a. Pertinent to the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Congestive Heart failure

Approximate Interval Between Onset and Death

weeks

Due to (or as a consequence of):

b.

Possible aspiration pneumonia

days

Due to (or as a consequence of):

c.

Severe peripheral vascular disease

year

Due to (or as a consequence of):

d.

multiple skin ulcers - sepsis

months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic A. fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

D48271

29d. Date signed (Month, Day, Year)

6-1-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FAHED KOUIS 7600 oster Dr. Suite 203 Towson, MD 21204

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17761

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GARY

JOHNSON

2. Date of Death

Month 5

Day 30

Year 1999

3. Time of Death

0700

4a. Facility Name (If not institution, give street and number)

VILLA ST. MICHEAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NIA

Funeral
Director

5. Social Security Number

216-42-4093

6. Sex

M 20 F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) AUG. 10, 1944

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

NIA

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

X Yes 2 No

10a. Street and Number

2307 N. ASHBURTON ST.

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 X Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

UNKNOWN

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

UNEMPLOYED

16b. Kind of Business/Industry

NIA

17. Father's Name (First, Middle, Last)

ULYSSES

JOHNSON

ESTHER

BAYTON

19a. Informant's Name/Relationship (Type, Print)

ESTHER SMITH (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2307 ASHBURTON ST. BALTIMORE, MD. 21216

20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARBUTUS MEMORIAL PARK 06-03-99 BALTIMORE, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

JOSEPH H. BROWN JR.

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE. BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC LUNG CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 months

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 X Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 X No

25. Was case referred to medical examiner?

1 Yes 2 X No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 X Nursing Home

5 Residence

8 Other (Specify)

27. Manner of Death

1 X Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 X Certifying Physician

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Deborah Irene Pierce

29c. License number

H45931

29d. Date signed (Month, Day, Year)

JUNE 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEBORAH I. PIERCE 7220 PARK HEIGHTS AVENUE BALTIMORE, MD 21208

State
Registrar

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

Sparks

107 0 1000 200

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17762

| | | | | | | | | | | | | |
|--|--|--|---------------------------------|---|---|--|--|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WILLIAM G. JUNG | | | | 2. Date of Death
Month MAY Day 31 Year 1999 | | | | 3. Time of Death
5:45 PM | | | |
| | 4a. Facility Name (If not institution, give street and number)
UNION MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | | | 4c. County of Death
N/A | | | |
| Funeral
Director | 5. Social Security Number
216-16-3328 | | 6. Sex
1 M 2 F | | 7. Age (In yrs. last birthday)
75 Yrs. | | 8. Date of Birth (Month, Day, Year)
12/17/23 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
PARKVILLE | | | | 10d. Inside City Limits
1 Yes 2 <input checked="" type="checkbox"/> No | | | | |
| 10e. Street and Number
7828 WENDOVER AVENUE | | | | 10f. Zip Code
21234 | | | | 10g. Citizen of What Country?
USA | | | | |
| 11. Marital Status
1 Never Married 2 <input checked="" type="checkbox"/> Married
3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
12th GRADE | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MACHINIST | | | | 16b. Kind of Business/Industry
RESEARCH AND DEVELOPMENT | | | | |
| 17. Father's Name (First, Middle, Last)
WILLIAM JUNG | | | | 18. Mother's Name (First, Middle, Maiden Surname)
THERESA HEID | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
MARGARET A. JUNG WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7828 WENDOVER AVENUE PARKVILLE, MD 21234 | | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
PARKWOOD CEMETERY | | Date
6/4/99 | | 20c. Location - City or Town, State
BALTIMORE, MD | | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
THE JOHNSON FUNERAL HOME, P.A.
8521 LOCH RAVEN BLVD. TOWSON, MD 21286 | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Non Hodgkins Lymphoma
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d. | | | | | | | | | | Approximate Interval Between Onset and Death
1 year | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 <input checked="" type="checkbox"/> No 3 Probably 4 Unknown | | | | |
| | | | | | | | | 24a. Was an autopsy performed?
1 Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | |
| 29b. Signature and title of certifier
 PHYSICIAN | | | | 29c. License number
D47123 | | | | 29d. Date signed (Month, Day, Year)
MAY 31, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. PUTHUMANAN UNION MEM-HOSP. BALTIMORE MD 21218 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 3 1999 | | | | 32. Registrar's Signature
 | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17763

| | | | | | | | | | |
|---|---|---|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
NANCY PEARL JONES | | | | 2. Date of Death
Month Day Year
MAY 31 1999 | | 3. Time of Death
17:05 | | |
| | 4a. Facility Name (If not institution, give street and number)
UNIVERSITY MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
214-68-4586 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
83 Yrs. | | 8. Date of Birth (Month, Day, Year)
JAN 16 1916 | | |
| | 9. Birthplace (State or Foreign Country)
SOUTH CAROLINA | | 10a. State
MARYLAND | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE CITY | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
731 SPRINGFIELD AVENUE | | 10f. Zip Code
21212 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
6th grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOUSEWORKER | | 16b. Kind of Business/Industry
PRIVATE | | 17. Father's Name (First, Middle, Last)
JULIAN REED | | 18. Mother's Name (First, Middle, Maiden Summa)
GEORGIA REED | |
| 19a. Informant's Name/Relationship (Type, Print)
Martin Anderson/Grandson | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8491 Accotink Rd., Mt. Air, Virginia 22079 | | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
KING MEMORIAL PARK | | 20c. Location - City or Town, State
6-3-99 BALTIMORE, MARYLAND | |
| 21. Signature of Funeral Service Licensee
<i>Barbara A. Brown</i> | | 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME PA
1206 W NORTH AVENUE | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <i>Cerebrovascular Accident</i>
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.
<i>170 Gastrointestinal bleeding;
Alzheimer's disease</i> | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>D. S. Jones</i> | | 29c. License number
D17537 | | 29d. Date signed (Month, Day, Year)
6.1.99 | | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
DAR SHAN S. SALUJANO 1600 W. MOUNT Royal Ave, Balto 21217 | |
| 31. Date filed (Month, Day, Year)
JUN - 3 1999 | | 32. Registrar's Signature
<i>James B. Jones</i> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17764

Amended Item#16a,19b perFH G772 6/3/99 EW

| | | | | | | | | | | |
|---|---|-------------------------------|--|--|--|--|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Joseph Matthew Kremer | | | | | 2. Date of Death
Month Day Year
May 27, 1999 | | 3. Time of Death
2:40A.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
North Arundel Hospital | | | | | 4b. City, Town, or Location of Death
Glen Burnie | | 4c. County of Death
Anne Arundel | | |
| Funeral
Director | 5. Social Security Number
217-26-5225 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
Yrs. 74 | | 8. Date of Birth (Month, Day, Year)
Oct 2, 1924 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Pasadena | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
1527 Shoreside Trail | | | | 10f. Zip Code
21122 | | 10g. Citizen of What Country?
U.S.A. | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1943 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Personnel Manager | | | 16b. Kind of Business/Industry
Amstar Corp. | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Joseph Kremer | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Magdalena Riedel | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Lillian D. Kremer (Wife) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Shoreside 1527 Shoreside Trail Pasadena, Maryland 21122 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Ht. of Jesus Cem. | | Date
6/1/99 | | 20c. Location - City or Town, State
Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
3204 Mountain Road Pasadena, Maryland 21122 | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Acute Aspiration
Due to (or as a consequence of):
b. Dementia
Due to (or as a consequence of):
c. ARACHNOID BRAIN CYST
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Seizure Disorder
Gastroesophageal Reflux Disease | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DUA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| State Registrar | 29b. Signature and Title of Certifier
 | | | | | 29c. License number
D-0032138 | | 29d. Date signed (Month, Day, Year)
05/30/99 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Alex HERTZMAN, MD 7845 OAKWOOD RD. #301 GLENBURNIE, MD. 21061 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | 32. Registrar's Signature
 | | | | | | | | |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17765

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

MARGARET A. KREBS

2. Date of Death

June 1st 1999

3. Time of Death

5:30 pm

4a. Facility Name (If not institution, give street and number)

Mariner Health of Bel Air

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

218-01-0133

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 7, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Abingdon

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

204 A. Oakleaf Circle

10f. Zip Code

21009

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Co-Owner/Treasurer

16b. Kind of Business/Industry

Furniture Store

17. Father's Name (First, Middle, Last)

Michael A. Stoecker

18. Mother's Name (First, Middle, Maiden Surname)

Anna M. Hoehn

19a. Informant's Name/Relationship (Type, Print)

Ronald A. Krebs (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 South Lynbrook Road, Bel Air, MD. 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem.

Date

6/4/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Robert J. Bodensky

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Road, Bel Air, MD. 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Renal Cell Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Scott Haswell MD

29c. License number

D34652

29d. Date signed (Month, Day, Year)

June 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scott Haswell 2 North Avenue Bel Air Maryland 21014

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

Anna B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Margaret Krebs

AH(2)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17766

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE HUNTLEY KING JR.

2. Date of Death

May 30, 1999

3. Time of Death

9:45 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

216-18-9786

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 18, 1925

9. Birthplace (State or Foreign)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Kingsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10804 Pfeffers Road

10f. Zip Code

21087

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1942-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Safety Analyst

16b. Kind of Business/Industry

BGE

17. Father's Name (First, Middle, Last)

George H. King Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Laura Sommer

19a. Informant's Name/Relationship (Type, Print)

Carol B. King (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10804 Pfeffers Road, Kingsville, MD. 21087

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

6/1/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Road, Bel Air, MD. 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Adenocarcinoma of the Lung

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D45475

29d. Date signed (Month, Day, Year)

MAY 30, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Mohammad Rahnama MD, 9000 Franklin Square Dr. Baltimore MD 21237

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

State
Registrar

King, George
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

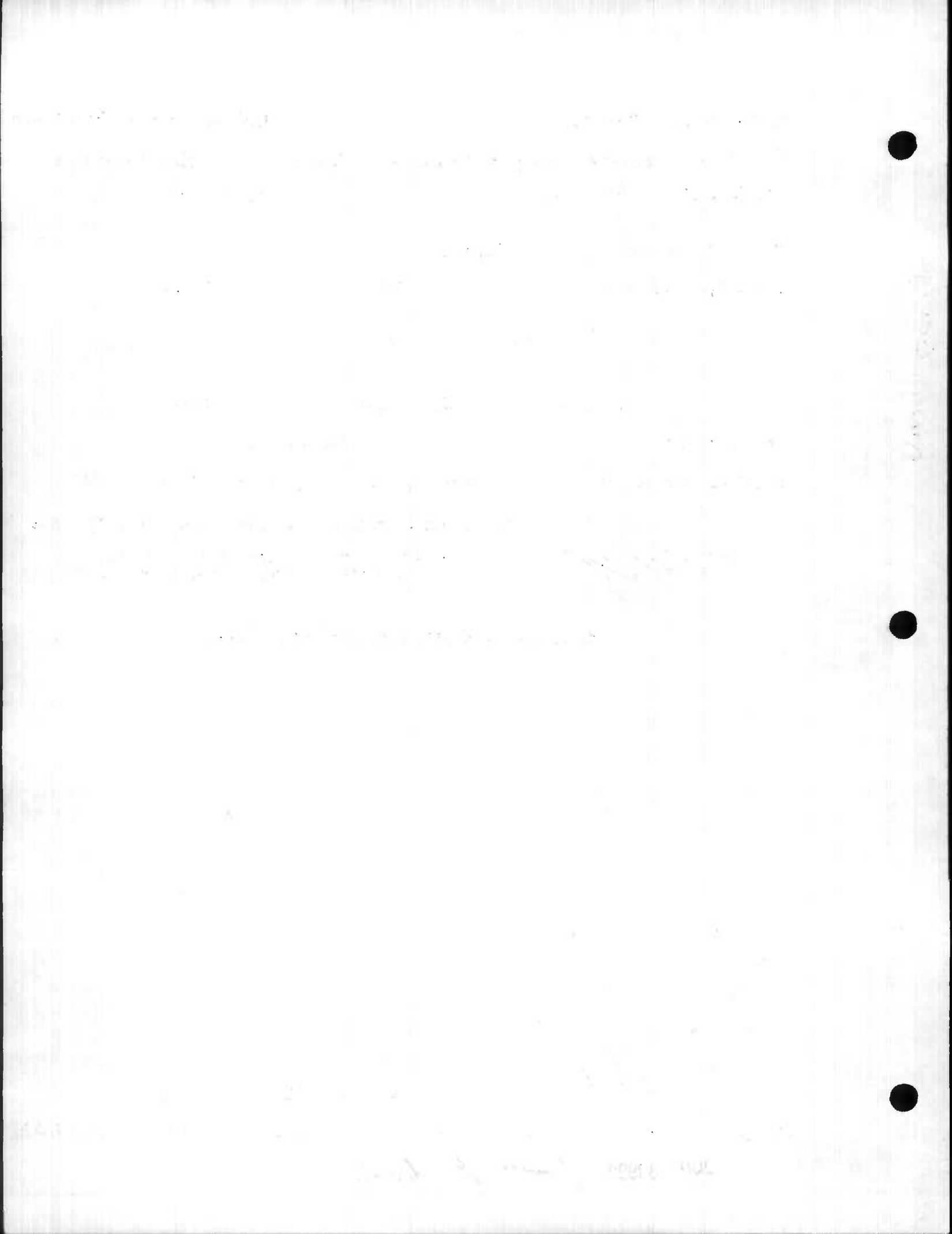
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

441041



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17767

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

STANLEY JAN KIHN

2. Date of Death

May 30, 1999

3. Time of Death

10:22 p.m.

4a. Facility Name (If not institution, give street and number)

Hamilton Nursing Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-28-9095

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 3, 1920

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Joppatowne

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

425 Larkspur Drive

10f. Zip Code

21085

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+ years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Health Inspector

16b. Kind of Business/Industry

Baltimore City

17. Father's Name (First, Middle, Last)

Stanley Kihn

18. Mother's Name (First, Middle, Maiden Surname)

Maria Kwiatowski

19a. Informant's Name/Relationship (Type, Print)

Jane G. Kihn (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

425 Larkspur Drive, Joppatowne, MD. 21085

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Rosary Cemetery

Date

6/3/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Robert J. Rodol

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Road, Bel Air, MD. 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 Months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert J. Rodol

29c. License number

D95475

29d. Date signed (Month, Day, Year)

6-2-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohamamod Rahnema, M.D., 17 Fontana Lane, Rosedale, MD. 21237

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

STANLEY KIHN

AH 12-1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17768

| | | | | | | | | | | | |
|---|---|--|---|---|---|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
NORMAN BARRY KESSLER | | | | | 2. Date of Death
Month Day Year
MAY 31 1999 | | 3. Time of Death
2217 | | | |
| | 4a. Facility Name (If not institution, give street and number)
19 LEXINGTON ROAD | | | | | 4b. City, Town, or Location of Death
HARMANS | | 4c. County of Death
ANNE ARUNDEL | | | |
| Funeral
Director | 5. Social Security Number
170-28-0300 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
63 Yrs. | | 8. Date of Birth (Month, Day, Year)
JAN. 20, 1936 | | 9. Birthplace (State or Foreign Country)
PENNSYLVANIA | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
HARMANS | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
19 LEXINGTON ROAD | | | | 10f. Zip Code
21077 | | 10g. Citizen of What Country?
UNITED STATES | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
4 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CRYPTOLOGIST | | | 16b. Kind of Business/Industry
FEDERAL GOVERNMENT | | | | |
| | 17. Father's Name (First, Middle, Last)
NORMAN LESTER KESSLER | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ROSE DIEHL | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
DEBORAH KNIGHT/DAUGHTER | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6 BENMERE ROAD GLEN BURNIE, MD 21060 | | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
METRO CREMATORY | | | 20c. Location - City or Town, State
CATONSVILLE, MD | | 20d. Date
JUNE 4, 1999 | | |
| | 21. Signature of Funeral Service Licensee
<i>William P. Jones</i> | | | | | 22. Name and Address of Facility
KIRKLEY-RODDICK FUNERAL HOME
421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061 | | | | | |
| | 23a. Part I. Enter the disease, or complication which caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <i>Arteriosclerotic Heart Disease</i>
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>William P. Jones, MD Deputy</i> | | | | | 29c. License number
D06054 | | 29d. Date signed (Month, Day, Year)
6/2/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>William P. Jones, MD 695 America 21035</i> | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | | | 32. Registrar's Signature
<i>B. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17769

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LILAE KELLIS

2. Date of Death

May 28 1999

3. Time of Death

9-40 PM

4a. Facility Name (If not institution, give street and number)

LIBERTY MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral
Director

5. Social Security Number

217-64-5092

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

05/09/1921

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4714 Park Heights Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

2

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Housekeeping

17. Father's Name (First, Middle, Last)

James Ganney

18. Mother's Name (First, Middle, Maiden Surname)

Ola Dunmore

19a. Informant's Name/Relationship (Type, Print)

Lilae Carter / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3116 Oakley Avenue, Baltimore, Maryland 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Date

06/05/99

20c. Location - City or Town, State

Landsdowne, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

The Derrick C. Jones Funeral Home

4611 Park Heights Ave., Baltimore, Maryland 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

ACUTE Cerebro-Vascular Accident

Due to (or as a consequence of):

End-stage Renal Disease with Renal FAILURE

Due to (or as a consequence of):

due to Diabetic Nephropathy.

Due to (or as a consequence of):

CHRONIC OBSTRUCTIVE LUNG DISEASE.

Approximate Interval Between Onset and Death

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. M. SHAH MD

29c. License number

D19608

29d. Date signed (Month, Day, Year)

MAY 28 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. M. SHAH, 2800 LIBERTY ST AVE, BALTIMORE, MD.

31. Date filed (Month, Day, Year)

JUN - 3 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Handwritten signature

REC-8-MUI

WRC
99-3092-510
UNK. 99-121

Michelle Lonon ITEMS: #23 PART I, 27 PER MEO G773 7-8-99

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17770

| | | | | | | |
|---|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MICHELLE LONON | | 2. Date of Death
Month Day Year
MAY 29, 1999 | | 3. Time of Death
5:00 PM. | |
| | 4a. Facility Name (If not institution, give street and number)
ST. AGNES HOSPITAL | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
218-76-3837 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
39 Yrs. | |
| | 8. Date of Birth (Month, Day, Year)
JULY 12, 1959 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE CITY | |
| | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| | 10e. Street and Number
1852 WILKENS STREET | | 10f. Zip Code
21223 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10TH GRADE
College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOUSEKEEPER | |
| | 16b. Kind of Business/Industry
HOLIDAY INN HOTELS | | 17. Father's Name (First, Middle, Last)
EDDIE MOSES | | 18. Mother's Name (First, Middle, Maiden Surname)
CARRIE EPPS | |
| | 19a. Informant's Name/Relationship (Type, Print)
LINDA MOSES (DAUGHTER) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
209 S. STRICKER STREET, BALTIMORE, MD 21223 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT. ZION CEMETERY | | 20c. Date
6-5-99 | |
| | 20d. Location - City or Town, State
LANSDOWNE, MARYLAND | | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE., BALTIMORE, MD 21217 | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL FIBROSIS AND HYPERTENSIVE CARDIOVASCULAR DISEASE
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
Yes 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death?
Yes 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
Yes 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
MAY 29, 1999 | | 28b. Time of Injury
M | | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | | |
| 29d. Date signed (Month, Day, Year)
MAY 30, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chuteau 111 Penn Street, Baltimore, Maryland 21201 | | 31. Date filed (Month, Day, Year)
JUN 3 1999 | | |
| 32. Registrar's Signature
 | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17771

| | | | | | | | | |
|--|---|---|--|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Monson LaBoo | | | | 2. Date of Death
Month May Day 29 Year 1999 | | 3. Time of Death
4:40 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Sinai Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
250-18-6312 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
83 Yrs. | | 8. Date of Birth (Month, Day, Year)
04 22 16 | |
| | 9. Birthplace (State or Foreign Country)
S.C. | | 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
2906 Woodland Ave | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
8th grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Welder | | 16b. Kind of Business/Industry
Koppers Corp. | | 17. Father's Name (First, Middle, Last)
Frank LaBoo | | |
| 18. Mother's Name (First, Middle, Maiden Sumame)
Zinia LaBoo | | 19a. Informant's Name/Relationship (Type, Print)
Roosevelt J. LaBoo-Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4 Fortnum Ct. Randallstown Md 21133 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus Memorial Park | | 20c. Location - City or Town, State
6/4/99 Arbutus, Md | | 21. Signature of Funeral Service Licensee
Gabriele Cook | | 22. Name and Address of Facility
March F/H West 4360 Wabash Ave, Baltimore Md 21215 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Aspiration pneumonia
Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | |
| 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and Title of Certifier
Resident Physician | | 29c. License number
P12343 | | |
| 29d. Date signed (Month, Day, Year)
May 29, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joel W. Walker, MD Sinai Hospital Baltimore MD 21215 | | 31. Date filed (Month, Day, Year)
JUN 3 1999 | | 32. Registrar's Signature
B. Sparks | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

99-3065-005

JOSEPH
LUKASZUK

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17772

| | | | | | | | | | |
|--|---|---|--|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Wayne Joseph Lukaszuk | | | | 2. Date of Death
Month Day Year
MAY 27, 1999 | | 3. Time of Death
6:00P.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
9802 WILBERT AVE | | | | 4b. City, Town, or Location of Death
PARKVILLE | | 4c. County of Death
BALTIMORE | | |
| Funeral
Director | 5. Social Security Number
213-52-8784 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
48 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 7 1950 | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD. | | 10b. County
Baltimore | | 10c. City, Town or Location
Parkville | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
9802 Wilbert Ave. | | 10f. Zip Code
21234 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+)
+4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Risk Management | | 16b. Kind of Business/Industry
Conrail | | 17. Father's Name (First, Middle, Last)
Joseph J. Lukaszuk | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Catherine Shuster | |
| 19a. Informant's Name/Relationship (Type, Print)
Mrs. Anne V. Lukaszuk/Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9802 Wilbert Ave. Parkville, MD. 21234 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Wiseburg Cemetery | | 20c. Location - City or Town, State
6-1-99 White Hall, MD. | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, MD. 21204 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Contact Shotgun Wound of Head
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
partial
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
Formal 5-27-99 | | 28b. Time of Injury
Formal 1749 P | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
self inflicted gunshot wound | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
home | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
9802 Wilbert Ave Parkville, Md | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 28, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chuter | | 31. Date filed (Month, Day, Year)
JUN - 3 1999 | | 32. Registrar's Signature
 | | 33. Registrar's Name
B. Sparks | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760, R

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17773

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Herman Lichtman

2. Date of Death

May 25 1999

3. Time of Death

954 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

204-14-7078

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 9 1907

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10e. State

PA.

10b. County

Montgomery

10c. City, Town or Location

Pottstown

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

104 South Mount Vernon St.

10f. Zip Code

19464

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

President

16b. Kind of Business/Industry

Hosiery Manufacturing

17. Father's Name (First, Middle, Last)

Jacob Lichtman

18. Mother's Name (First, Middle, Maiden Surname)

Dora Brust

19a. Informant's Name/Relationship (Type, Print)

Mrs. Franya Lichtman/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

104 South Mount Vernon St. Pottstown, PA. 19464

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Congregation Mercy & Truth Cemetery

Date

5-27-99

20c. Location - City or Town, State

Pottstown, PA.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd., Towson, MD. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. myocardial infarction

Due to (or as a consequence of):

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. cardiogenic shock

Due to (or as a consequence of):

1 day

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

none

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

97025

29d. Date signed (Month, Day, Year)

May 25, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Samantha Shah, M.D. 4940 Eastern Avenue, Baltimore, Maryland 21224

31. Date filed (Month, Day, Year)

JUN - 3 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

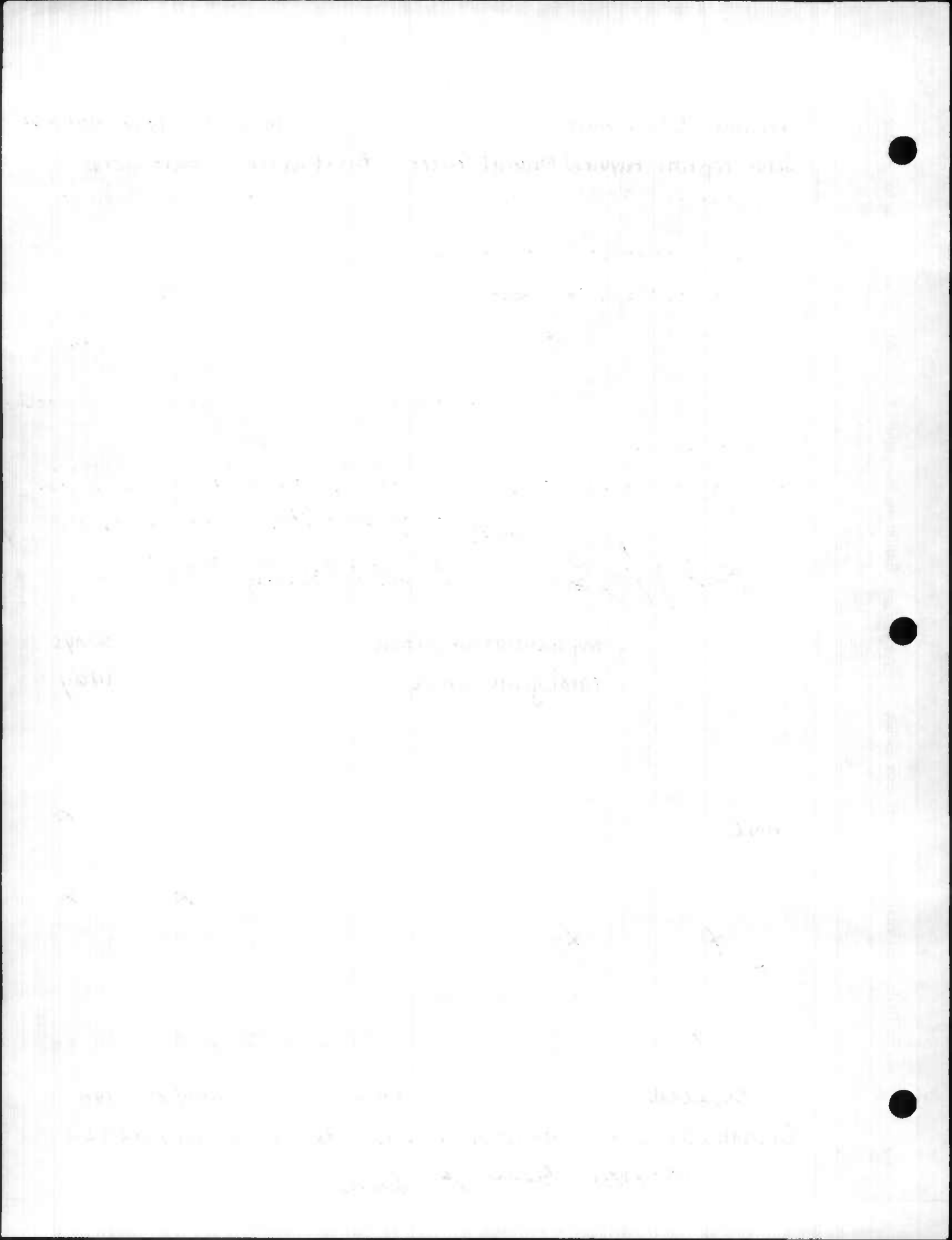
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



99 1777i

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17775

| | | | | | | | | |
|--|--|--|--------------------------|---|---|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
VINCENT E LUBRESKI | | | | 2. Date of Death
Month MAY Day 28 Year 1999 | | 3. Time of Death
00:56 | |
| | 4a. Facility Name (If not institution, give street and number)
UNIVERSITY OF MARYLAND MEDICAL SYSTEM | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
219-38-2318 | | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
56 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
10/30/1942 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
1 X Yes 2 No | |
| 10e. Street and Number
2219 Chesterfield Avenue | | | | 10f. Zip Code
21213 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
1 Never Married 2 Married 3 Widowed 4 X Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 No
If Yes, Give Year or Dates: 1960-64 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 X Yes 2 No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 1 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Taxi(cab) Driver | | | 16b. Kind of Business/Industry
Transportation | |
| 17. Father's Name (First, Middle, Last)
Edward Thomas Lubreski | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Jean Lubreski | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Jean Lubreski/Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2219 Chesterfield Avenue, Baltimore, Maryland 21213 | | | | |
| 20a. Method of Disposition
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Stanislaus Cemetery | | 20c. Location - City or Town, State
06/01/99 Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee
Christina L. David | | | | 22. Name and Address of Facility
Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, Maryland 21214 | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. MULTIPLE ORGAN SYSTEMS FAILURE
Due to (or as a consequence of):
b. SEPTIC SHOCK
Due to (or as a consequence of):
c. PANCREATITIS
Due to (or as a consequence of):
d. END STAGE LIVER DISEASE | | | | Approximate Interval Between Onset and Death | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
IMMUNOSUPPRESSION | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 X Yes 2 No 3 Probably 4 Unknown | | |
| | | | | | | 24e. Was an autopsy performed?
1 X Yes 2 No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 X Yes 2 No | | |
| 25. Was case referred to medical examiner?
1 X Yes 2 No | | | | 26. Place of Death (Check only one)
Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | |
| 27. Manner of Death
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 X Yes 2 No | | 28d. Describe how Injury occurred |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
ALSA (RESIDENT PHYSICIAN) | | | | 29c. License number
P1160 | | 29d. Date signed (Month, Day, Year)
5/28/1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
EVERLYN ALISA - DEPT OF ANESTHESIOLOGY, 22 S. GREENE ST. BALTIMORE, MD. | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 03 1999 | | | | 32. Registrar's Signature
B. Sparks | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17776

| | | | | | | | | |
|---|---|---|---|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Stephen Michael McFadden | | | | 2. Date of Death
Month Day Year
May 25, 1999 | | 3. Time of Death
10:55 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Route 24 North Bound, South of Tollgate Road | | | | 4b. City, Town, or Location of Death
Abingdon | | 4c. County of Death
Harford | |
| Funeral
Director | 5. Social Security Number
219-98-5933 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
33 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Nov. 6, 1965 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | | |
| | 10a. State
Md. | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
2810 Washington Blvd. | | | | 10f. Zip Code
21230 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Supervisor | | | 16b. Kind of Business/Industry
Warehouse | | |
| | 17. Father's Name (First, Middle, Last)
Edward Joseph McFadden | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Patricia R. Walters | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Margaret McFadden / Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
75 Broadship Rd., Dundalk, Md. 21222 | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Balto.-Wash. Crematory | | 20c. Location - City or Town, State
Laurel, Md. | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Bradley-Ashton-Matthews Funeral Home, Inc
2134 Willow Spring Rd., Balto., Md. 21222 | | | |
| | Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Injuries
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
5/25/99 | | 28b. Time of Injury
2:00 PM | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred
Pedestrian struck by auto | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Street | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)
RT 24 N/B (South of Tollgate) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
May 27, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | | 32. Registrar's Signature
 | | | |

1000

1000

1000

1000

1000

1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17777

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia T. May

2. Date of Death
Month Day Year
June 1, 19993. Time of Death
Noon

4a. Facility Name (If not institution, give street and number)

Manor Care Roland Park

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

218-14-0734

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 14, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1403 Medfield Avenue

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Cashier

16b. Kind of Business/Industry

Retail Sales

17. Father's Name (First, Middle, Last)

Robert Talbott

18. Mother's Name (First, Middle, Maiden Surname)

Ada Childress

19a. Informant's Name/Relationship (Type, Print)

Glenn B. May, Sr. Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1403 Medfield Avenue Baltimore, Maryland 21211

20a. Method of Disposition

1 ☐ Burial ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Baltimore-Washington

Data

6/6/99

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, MD 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Emphysema

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D23076

29d. Date signed (Month, Day, Year)

6-3-99

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

RICHARD L DIAMOND

3730 Falls Rd Baltimore Md 21211

31. Date filed (Month, Day, Year)

JUN 03 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 302-358-5000.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17778

| | | | | | | | | | | |
|---|--|---------------------------|---|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Clement R. Miller | | | | | | 2. Date of Death
Month MAY Day 28 , Year 1999 | | 3. Time of Death
06:15 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center | | | | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
220-07-4784 | | 6. Sex
XX M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
88 Yrs. | | 8. Date of Birth (Month, Day, Year)
Nov. 20, 1910 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
432 Fawcett Street | | | | 10f. Zip Code
21211 | | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Director Computer Department | | | 16b. Kind of Business/Industry
Maryland State Police | | | |
| 17. Father's Name (First, Middle, Last)
John Miller | | | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Nellie Mac Gonical | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Elizabeth Miller Wife | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
432 Fawcett Street Baltimore, Maryland 21211 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Memorial | | | Date
6/1/99 | | 20c. Location - City or Town, State
Cockeysville, Maryland | | |
| 21. Signature of Funeral Service Licensee
Reyn B. Henss | | | | | | 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
ACUTE MYOCARDIAL INFARCTION | | | | | | | | | | Approximate Interval Between Onset and Death
1 WEEK |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
Beatriz P. Dizon, M.D. | | | | | | 29c. License number
D 16492 | | 29d. Date signed (Month, Day, Year)
May 28, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BEATRIZ P. DIZON, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 03 1999 | | | | | | 32. Registrar's Signature
Benjamin S. Sparks | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17770

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
Director

| | | | | | |
|---|--|---|--------------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last)
ROBERT MCMORRIS | | 2. Date of Death
Month Day Year
May 27, 1999 | | 3. Time of Death
10:30 A.M. | |
| 4a. Facility Name (If not institution, give street and number)
1813 North Dukeland Street | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| 5. Social Security Number
UNKNOWN | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
72 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
3-14-27 |
| 9. Birthplace (State or Foreign Country)
NEWBERRY, SC | | | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
1813 DUKELAND ST | | | |
| 10f. Zip Code
21216 | | 10g. Citizen of What Country?
U.S.A. | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SELF EMPLOYED | | 16b. Kind of Business/Industry
SELF EMPLOYED | | | |
| 17. Father's Name (First, Middle, Last)
ILLENOICE MCMORRIS | | 18. Mother's Name (First, Middle, Maiden Surname)
AGNOIA JACKSON | | | |
| 19a. Informant's Name/Relationship (Type, Print)
DELORES MCMORRIS (WIFE) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4530 ROGERS AVE, BALTO. MD 21207 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARBUTUS CEMETERY | | 20c. Location - City or Town, State
6-2-99 BALTO. COUNTY | |
| 21. Signature of Funeral Service Licensee
<i>Wall & Howell</i> | | 22. Name and Address of Facility
LEROY O DYETT & SON FUNERAL HOME
4600 LIBERTY HGHTS AVE, BALTO. MD 21207 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
ACUTE NARCOTIC INTOXICATION
Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Asthma ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | | | | | |
| 23c. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
partial
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
<i>Dennis J. Chute</i> | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
May 28, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 4 1999 | | 32. Registrar's Signature
<i>B. Sparks</i> | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17780

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ADA McDOWELL

2. Date of Death

Month Day Year
5-24-99

3. Time of Death

9:50

4a. Facility Name (If not institution, give street and number)

566 WEST PRESTON STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral
Director

5. Social Security Number

239-09-8450

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
3-29-08

9. Birthplace (State or Foreign Country)

SC.

Usual Residence of Decedent

10a. State

MD.

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

566 WEST PRESTON STREET

10f. Zip Code

21201

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

THOMAS YOUNG

18. Mother's Name (First, Middle, Maiden Surname)

MORIAH YOUNG

19a. Informant's Name/Relationship (Type, Print)

JACKIE McCLOUD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

566 WEST PRESTON STREET BALTIMORE MD. 21201

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore National

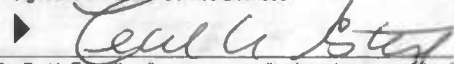
Date

5-27-99

20c. Location - City or Town, State

Baltimore Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.

1300 EUTAW PLACE BALTIMORE MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cerebrovascular Accident

Due to (or as a consequence of):

b. Dementia

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D32263

29d. Date signed (Month, Day, Year)

5/27/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHRISTIE LAMPING 2000 W BALTIMORE 21223

State Registrar

31. Date filed (Month, Day, Year)

JUN 03 1999

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17781

| | | | | | | | | |
|--|---|---|---|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WANDA FISHER MCCREE | | | | 2. Date of Death
Month Day Year
MAY 25 1999 | | 3. Time of Death
00:09 | |
| | 4a. Facility Name (If not institution, give street and number)
ST AGNES HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
219-54-4780 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
48 Yrs. | 8. Under 1 Year
Months Days | 9. Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
5-14-51 | 9. Birthplace (State or Foreign Country)
MD. | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD. | | 10b. County | | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number
3406 W. NORTH AVE. | | | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+)
12 | | | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
HEALTH CARE | | | 16b. Kind of Business/Industry
CITY OF BALTIMORE | |
| 17. Father's Name (First, Middle, Last)
NOBLE FISHER SR. | | | | 18. Mother's Name (First, Middle, Maiden Summa)
ELSIE E. FISHER | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
TAWANNA FISHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3406 W. NORTH AVE. BALTIMORE, MARYLAND 21216 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARBUTUS MEM PARK | | 20c. Location - City or Town, State
5-29-99 ARBUTUS, MD. | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PLACE BALTIMORE, MARYLAND 21217 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <u>Acute myocardial infarction</u>
Due to (or as a consequence of):
b. <u>Coronary artery disease</u>
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d. _____
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
1 hour
5 years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>diabetes mellitus</u>
<u>chronic renal failure, dialysis dependent</u>
<u>hypertension</u> | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D 2264F | | 29d. Date signed (Month, Day, Year)
MAY 25, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Jerome J. Snyder, M.D. 900 SOUTH CATON AVENUE BALTIMORE, MARYLAND 21229 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 03 1999 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

NAME FISHER - MCCREE, WANDA
Division of Vital Records, P.O. Box 68760,
Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar
DHHM 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17782

| | | | | | |
|---|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ADA MADDOX | | 2. Date of Death
Month Day Year
MAY 31, 1999 | | 3. Time of Death
9:08AM |
| | 4a. Facility Name (If not institution, give street and number)
CHURCH HOME NURSING CENTER | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
218-09-3304 | 6. Sex
1 <input type="checkbox"/> M 2 <input type="checkbox"/> F
X | 7. Age (In yrs. last birthday)
85 Yrs. | 8. Date of Birth (Month, Day, Year)
NOV. 23, 1913 | 9. Birthplace (State or Foreign Country)
NORTH CAROLINA |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | 10b. County
N/a | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
1916 HOPE STREET | | 10f. Zip Code
21218 | | 10g. Citizen of What Country?
U.S.A |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: AFRO-AMERICAN | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+)
UNKNOWN UNKNOWN | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
LABORER | | 16b. Kind of Business/Industry
CONTINENTAL CAN CO. | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
UNKNOWN | | 18. Mother's Name (First, Middle, Maiden Surname)
UNKNOWN | | |
| | 19a. Informant's Name/Relationship (Type, Print)
MARY MALONE / niece | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1916 HOPE ST. BALTO. BALTO, MD. 21212 | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place).
Maryland National | | 20c. Location - City or Town, State
JUNE 4, 1999 Laurel, Md. |
| | 21. Signature of Funeral Service Licensee
<i>Calvin B. Scruggs</i> | | 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON STREET BALTO, MD. 21212 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Probable Acute Myocardial infarction 6 hrs
Due to (or as a consequence of):
b. Atherosclerotic Cardiovascular disease 5 yrs
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>S. Clark</i> | | 29c. License number
D30641 | |
| | | 29d. Date signed (Month, Day, Year)
JUNE 1, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RAMESH SABAPATHI SUITE 308 821 N. EUTAW ST. BALTO, MD. 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | 32. Registrar's Signature
<i>James B. Sparks</i> | | | |

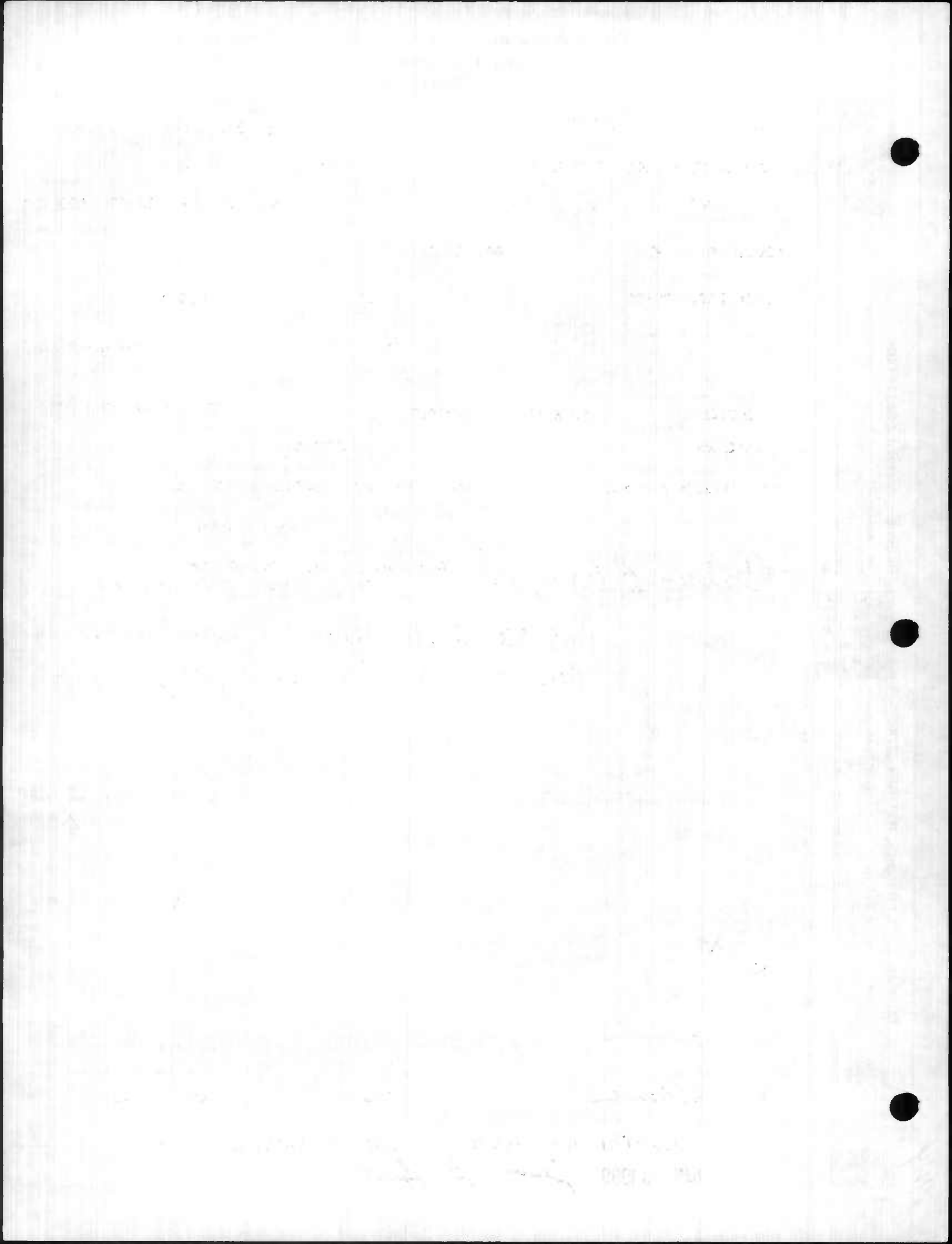
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17783

| | | | | | | | | |
|---|--|---|---|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Mary E. Maddox | | | | 2. Date of Death
Month Day Year
May 28 1999 | | 3. Time of Death
8:30am | |
| | 4a. Facility Name (If not institution, give street and number)
2853 West Lafayette Ave | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
075-18-6841 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
79 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
09 19 19 | 9. Birthplace (State or Foreign Country)
N.C. |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 10e. Street and Number
2853 West Lafayette Ave | | | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th grade
College (1-4 or 5+) na | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Beautician | | 16b. Kind of Business/Industry
Self Employed | | | |
| | 17. Father's Name (First, Middle, Last)
Abner Spellman | | | | 18. Mother's Name (First, Middle, Maiden Sumama)
Ella Cox | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Francis Maddox-Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2853 West Lafayette Ave, Baltimore Md 21216 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest Vet | | Date
6/1/99 | | 20c. Location - City or Town, State
Owings Mills, Md | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CARCINOMA COLON WITH METASTASES
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death
4 MONTHS |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>[Signature]</i> | | | | | | |
| 29c. License number
D 06933 | | 29d. Date signed (Month, Day, Year)
MAY 28 1999 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
JOHN B. MCGIBBON, MD 101 W. READ ST BALTIMORE 21201 MD. | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17784

| | | | | | | | | | |
|---|---|---|---|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GERTRUDE MELTON | | | | 2. Date of Death
Month Day Year
MAY 27 1999 | | 3. Time of Death
3:00 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
SINAI HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death | | |
| Funeral
Director | 5. Social Security Number
220-24-4616 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
80 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
03 16 19 | 9. Birthplace (State or Foreign Country)
S.C. | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
5311 Gist Ave | | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
U.S.A. | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th grade
College (1-4 or 5+) na | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Maid | | 16b. Kind of Business/Industry
Lord Baltimore Hotel | | | |
| 17. Father's Name (First, Middle, Last)
Berdine Walker | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Cassie | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Lisch Melton-Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5311 Gist Ave, Baltimore Md 21215 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Park | | Date
6/2/99 | | 20c. Location - City or Town, State
Randallstown, Md | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

<div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> <p>a. SEVERE RESPIRATORY INSUFFICIENCY
Due to (or as a consequence of):</p> <p>b. MRSA SEPSIS
Due to (or as a consequence of):</p> <p>c. GI Bleed - recurrent
Due to (or as a consequence of):</p> <p>d.</p> </div> </div> | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

FRACTURE LEFT HIP 5/19/99

COAGULOPATHY

CHRONIC ATRIAL FIBRILLATION | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
RESIDENT PHYSICIAN | | | | 29c. License number
RES 000 | | 29d. Date signed (Month, Day, Year)
MAY 27, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JAMELLE R. BOWERS, MD SINAI HOSPITAL BALTIMORE, MARYLAND 21215-5271 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17785

| | | | | | | | | |
|--|--|--------------------------|---|---|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
KATIE MATHEWS | | | | 2. Date of Death
Month Day Year
05-31-99 | | 3. Time of Death
6:55 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Bon Secour Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
217-20-8855 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
79 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
05 11 20 | 9. Birthplace (State or Foreign Country)
N.C. |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number
717 North Longwood Street | | | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th grade
College (1-4 or 5+) na | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Domestic Worker | | 16b. Kind of Business/Industry
Private | | |
| 17. Father's Name (First, Middle, Last)
Jim Pearsall | | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Kate Barden | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Norma Mathews-Daughter | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 299, Owings Mills, Md 21117 | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery | | 20c. Location - City or Town, State
6/4/99 Baltimore Co., Md | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore Md 21215 | | | | |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Pancytopenia
malnutrition | | | | | | | | Approximate Interval Between Onset and Death |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 23c. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> MD | | | | 29c. License number
DO016263 | | 29d. Date signed (Month, Day, Year)
05-31-99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MAN A. BELTRAN 1940 W. BAL ST, BAL MD 21223 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17786

| | | | | | | | | |
|---|--|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LIANNA I. M. MCKINNEY | | | | 2. Date of Death
Month JUNE Day 1 , Year 1999 | | 3. Time of Death
4:54 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
FRANKLIN SQUARE HOSPITAL | | | | 4b. City, Town, or Location of Death
ESSEX | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
217-51-8704 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
Yrs. _____ | | 8. Date of Birth (Month, Day, Year)
FEBRUARY 7, 1998 | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country)
MD | | 10a. State
MD | | 10b. County
NA | |
| To Be Completed by Funeral Director | 10c. City, Town or Location
BALTIMORE | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
5726 Onnen Rd | |
| | 10f. Zip Code
21206 | | | | 10g. Citizen of What Country?
USA | | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| To Be Completed by Physician/Medical Examiner | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: AFRICAN AMERICAN | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
NONE | | 16b. Kind of Business/Industry
NA | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
WAYNE HUTCHINS | | | | 18. Mother's Name (First, Middle, Maiden Surname)
TINIKA MCKINNEY | | | |
| | 19a. Informant's Name/Relationship (Type, Print) MOTHER
TINIKA MCKINNEY | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5726 Onnen Rd BALTIMORE, MD 21206 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARBUTUS MEMORIAL PARK 6-4-99 BALTIMORE, MD | | 20c. Location - City or Town, State
BALTIMORE, MD | |
| | 21. Signature of Funeral Service Licensee
[Signature] | | | | 22. Name and Address of Facility
Albert R. Wylie Funeral Hm PA 638 N. GILMORE ST. BALTIMORE, MD 21207 | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Injuries
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 28. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year)
6-1-99 | | 28b. Time of Injury
1610 M | |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred
pedestrian hit by car | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
702 Middleborough Baltimore, Md | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | 29b. Signature and title of certifier
[Signature] |
| | 29c. License number
O.C.M.E. | | | | | | | 29d. Date signed (Month, Day, Year)
JUNE 2, 1999 |
| State Registrar | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
Dennis J. Chute mo 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | 31. Date filed (Month, Day, Year)
JUN 3 1999 |
| | 32. Registrar's Signature
[Signature] | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17787

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jessie Primdahl McDonald

2. Date of Death

May 28 1999

3. Time of Death

10:15 AM

4a. Facility Name (If not institution, give street and number)

13704 Harcum Road

4b. City, Town, or Location of Death

Phoenix

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

223-38-0933

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 18, 1925

9. Birthplace (State or Foreign Country)

Denmark

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3005 Teak Lane

10f. Zip Code

20715

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Niels Christensen

18. Mother's Name (First, Middle, Maiden Surname)

Ane Andersen

19a. Informant's Name/Relationship (Type, Print)

Leo McDonald/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3005 Teak Lane Bowie, MD 20715

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

6/2/99

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

Fodd E. Liller

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.

16000 Annapolis Rd. Bowie, MD 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ANAPLASTIC THYROID

Due to (or as a consequence of):

CARCINOMA

Approximate Interval Between Onset and Death

2 mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence8 ☒ Other (Specify)

Daughter's Home

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph J. Liller

29c. License number

D. 22334

29d. Date signed (Month, Day, Year)

05. 28. 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph J. Liller 3901 Greenspring Ave Suite 300 BALTIMORE MD 21211

State
Registrar

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

Joseph J. Liller

ORIGINAL

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17788

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ellison McCrae

2. Date of Death

Month

Day

Year

3. Time of Death

1500

4a. Facility Name (If not institution, give street and number)

University of Maryland Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral
Director

5. Social Security Number

214 50 1251

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

07/06/48

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1707 BRUNT ST.

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

COOK

16b. Kind of Business/Industry

RACETRACK

17. Father's Name (First, Middle, Last)

THOMAS

MCCRAE

18. Mother's Name (First, Middle, Maiden Surname)

MADGALENE SULLERS

19a. Informant's Name/Relationship (Type, Print)

SHIRLENE MCCRAE /WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1707 BRUNT ST. BALTIMORE, MD. 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Voshells

Date

6/5/99

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service Licensee

James A. Morton

22. Name and Address of Facility

JAMES A. MORTON & SONS F.H., INC

1701 LAURENS STREET BALTO., MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Pneumothorax
Due to (or as a consequence of):b. Pneumonia
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

1 hour

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lung Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

J. A. Morton

29c. License number

P11747

29d. Date signed (Month, Day, Year)

May 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raymond Cross M.D. 2729 S. Paul St Unit 2 Baltimore MD 21218

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

James A. Morton

State
Registrar

Baltimore, Maryland 21215-0020

pamit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
document.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17789

| | | | | | | | | | | |
|---|--|--|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Jane E. Nash | | | | | | 2. Date of Death
Month Day Year
May 31 1999 | | 3. Time of Death
11:52 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Union Memorial Hospital | | | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
218-26-8860 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
69 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 8, 1930 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number
1323 W. 37th Street | | | | 10f. Zip Code
21211 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Own Home | | |
| | 17. Father's Name (First, Middle, Last)
Ernest Sidney Bortle | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Estella Gosnell | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Mary Woolford Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1214 Cape Sable Drive, Westminster, Maryland 21158 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery | | Data
6/4/99 | | 20c. Location - City or Town, State
Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee
B. Henss | | | | 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc 21211
3631 Falls Road, Baltimore, Maryland | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure
Due to (or as a consequence of):
b. Severe Mitral Valve Regurgitation
Due to (or as a consequence of):
c. Rheumatic Heart Disease
Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death
2 weeks
14 years
14 years | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
End Stage Renal Disease, COPD, CAD, Rheumatic Heart Disease, Gastrointestinal bleeding, Hepatic Dysfunction. | | | | | | | | | |
| State
Registrar | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
S. Sparks, MD | | 29c. License number
P12568 | | 29d. Date signed (Month, Day, Year)
May 31, 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
201 E. University Parkway, Baltimore MD 21218 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
JUN 03 1999 | | 32. Registrar's Signature
S. Sparks | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17790

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Marie Nash

2. Date of Death

June 2 1999

3. Time of Death

0024

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

5. Social Security Number

087-12-3455

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 23, 1921

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

FULLERTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4 DUNCROFT CT. APT T-B

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

EXECUTION CLERK

16b. Kind of Business/Industry

CLAREN COUNTY, N.J.
SHERIFFS OFFICE

17. Father's Name (First, Middle, Last)

FREDERICK HAYES

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH WADE

19a. Informant's Name/Relationship (Type, Print)

JENNY PADGETT

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 DUNCROFT CT. APT T-B FULLERTON, MD. 21236

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)EVANS FUNERAL CHAPEL
BAL MD - P.A.

Date

JUNE 5
1999

20c. Location - City or Town, State

FOREST HILL, MD

21. Signature of Funeral Service Licensee

Krista S. Wells

22. Name and Address of Facility

EVANS CHAPEL OF MEMORIES
5800 HARFORD RD. PARKVILLE, MD. 2123423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Acute Pulmonary Edema

Due to (or as a consequence of):

b. Congestive Cardiomyopathy

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

1 hour

1 year

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Andrew Sumner, MD

29c. License number

D25753

29d. Date signed (Month, Day, Year)

June 2, 1999

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

J. Andrew Sumner, MD

Good Samaritan Hospital

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17791

| | | | | | | | | |
|---|--|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DORIS CATHERINE NACCI | | | | 2. Date of Death
Month Day Year
May 29, 1999 | | 3. Time of Death
8 p.m. | |
| | 4a. Facility Name (If not institution, give street and number)
8449 Maryland Road | | | | 4b. City, Town, or Location of Death
Pasadena | | 4c. County of Death
Anne Arundel Co. | |
| Funeral
Director | 5. Social Security Number
216-18-4317 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
75 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 12, 1924 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Anne Arundel Co. | | 10c. City, Town or Location
Pasadena | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
8449 Maryland Road | | 10f. Zip Code
21122 | |
| | 10g. Citizen of What Country?
U.S.A. | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | | 16b. Kind of Business/Industry
Own Home | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
George Juratovac | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Katherine Hicks | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Yvonne Barton Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8440 Geneva Road Pasadena, Maryland 21122 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GreenMount Crematory June 3, 1999 | | 20c. Location - City or Town, State
Baltimore, Maryland | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21122 | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery Disease
Due to (or as a consequence of):
b. Mitral Regurgitation
Due to (or as a consequence of):
c. Hyperlipidemia
Due to (or as a consequence of):
d. | | | | Approximate Interval Between Onset and Death | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
 M.D. | | | |
| To Be Completed by Physician/Medical Examiner | 29c. License number
D 36900 | | | | 29d. Date signed (Month, Day, Year)
6-1-1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Krishan K. SINGAR; 415 Grain Hwy. SE; GLENBURNIE MD 21061 | | | | 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature
 | | | | 33. Date of Death (Month, Day, Year)
JUN 3 1999 | | | |
| | 34. Registrar's Title
J. B. Sparks | | | | 35. Registrar's Signature
 | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17792

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nancy L. O'Hara

2. Date of Death
Month Day Year
06 01 99

3. Time of Death
10:00 AM

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

PG

Funeral
Director

5. Social Security Number

273-28-2884

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Feb. 15, 1930

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3374 Crumpton S.

10f. Zip Code

20724

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerical

16b. Kind of Business/Industry

Business

17. Father's Name (First, Middle, Last)

Alan G. Newton

18. Mother's Name (First, Middle, Maiden Surname)

Ella V. Galbreath

19a. Informant's Name/Relationship (Type, Print)

John P. O'Hara/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3374 Crumpton S., Laurel, Maryland 20724

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Veterans Cemetery

Date

6/4/99

20c. Location - City or Town, State

Crownsville, Maryland

21. Signature of Funeral Director

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Road, Laurel, Maryland 20707

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPTIC SHOCK

Due to (or as a consequence of):

b. UNOBTAINED URINARY TRACT INFECTION

Due to (or as a consequence of):

c. COMPLICATED MYOCARDIAL INFARCT

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death
48°

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CARDIOGENIC SHOCK

ISCHEMIC CARDIOMYOPATHY

MITRAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home

5 ☐ Residence

8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. George

29c. License number

36822

29d. Date signed (Month, Day, Year)

6/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. B. CRONIN 2405 MURKOVUE RD #3071 LAUREL, MD 20704

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

B. Spauls

20854

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

4410

Handwritten text, mostly illegible due to extreme fading. The text appears to be organized into several paragraphs or sections, possibly containing names, dates, and descriptive notes. The handwriting is cursive and somewhat slanted.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17793

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

| | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
Norman W. Porter | | | | | | 2. Date of Death
Month Day Year
MAY 30, 1999 | | 3. Time of Death
1:30 AM | |
| 4a. Facility Name (If not Institution, give street and number)
411 Waverly Avenue | | | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| 5. Social Security Number
213-28-7753 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
66 Yrs. | | 8. Date of Birth (Month, Day, Year)
DEC. 13, 1932 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
411 Waverly Avenue | | | | | | 10f. Zip Code
21225 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Mechanic | | | 16b. Kind of Business/Industry
Grain Exporter | | |
| 17. Father's Name (First, Middle, Last)
James E. Porter | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Elizabeth Nagel | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Ray R. Porter, Sr. - brother | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
123 W. Meadow Rd., Baltimore, Md. 21225 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Memorial Pk. | | Date
6/2/99 | | 20c. Location - City or Town, State
Elkridge, Md. | |
| 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc.
7250 Washington Blvd., Elkridge, Md. 21075 | | | |

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|-----------------------------------|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.


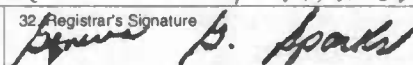
Immediate Cause (Final disease or condition resulting in death)
a. <u>metastatic rectal cancer</u>
Due to (or as a consequence of):

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death
2 years | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

_____ | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
022782 | | 29d. Date signed (Month, Day, Year)
June 1, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Aron W Berkman MD 3001 S. Hanover St, Baltimore, Md 21230 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | | 32. Registrar's Signature
 | | | | | |

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MDLATE

A410+1

| | | | | | | | | | | |
|---|---|---------------------------------------|---|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
James E. Parsley | | | | 2. Date of Death
Month May Day 26 , Year 1999 | | 3. Time of Death
1630 PM | | | |
| | 4a. Facility Name (If not institution, give street and number)
217 COLGATE ROAD | | | | 4b. City, Town, or Location of Death
DUNDALK | | 4c. County of Death
BALTIMORE | | | |
| Funeral
Director | 5. Social Security Number
216-96-4357 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
34 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sept. 20, 1964 | | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
Md. | | 10b. County
Baltimore | | 10c. City, Town or Location
Dundalk | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
7019 Sollers Point Road | | | | 10f. Zip Code
21222 | | 10g. Citizen of What Country?
U.S.A. | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Driver | | | 16b. Kind of Business/Industry
Cab Driver | | | |
| 17. Father's Name (First, Middle, Last)
James Parsley | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Lee Gilliam | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Douglas Gullede/S. Father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7019 Sollers Point Rd., Balto., Md. 21222 | | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Balto.-Wash-Crematory | | | Date
6-1-99 | | 20c. Location - City or Town, State
Laurel, Md. | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Bradley-Ashton-Matthews Funeral Home, Inc
2134 Willow Spring Rd., Balto., Md. 21222 | | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SEIZURE DISORDER
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. | | | | | | | Approximate Interval Between Onset and Death | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
MAY 27, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
H. S. Roberts 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | | 32. Registrar's Signature
 | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17795

| | | | | | | | | | |
|--|---|---|---|--|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Ida Bernice Poole</u> | | | | 2. Date of Death
Month Day Year
<u>MAY 30, 1999</u> | | 3. Time of Death
<u>6:25 AM</u> | | |
| | 4a. Facility Name (If not institution, give street and number)
<u>Saint Joseph Medical Center</u> | | | | 4b. City, Town, or Location of Death
<u>Towson</u> | | 4c. County of Death
<u>Baltimore</u> | | |
| Funeral
Director | 5. Social Security Number
<u>212-09-2644</u> | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>85</u> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<u>Oct 24 1913</u> | 9. Birthplace (State or Foreign Country)
<u>Maryland</u> | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
<u>Md</u> | 10b. County
<u>Baltimore</u> | 10c. City, Town or Location
<u>Glen Arm</u> | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
<u>11630 Glen Arm Rd apt. U-29</u> | | | | 10f. Zip Code
<u>21057</u> | | 10g. Citizen of What Country?
<u>USA</u> | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>White</u> | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>unknown</u> College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>secretary</u> | | | 16b. Kind of Business/Industry
<u>Towson State</u> | | | |
| | 17. Father's Name (First, Middle, Last)
<u>Alexander Selby</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Barbara Voith</u> | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
<u>Thomas L. Poole Jr.</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>1505 Rayville Rd. Parkton, Md 21120</u> | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Gardens of Faith Ceme.</u> | | Date
<u>June 3 1999</u> | | 20c. Location - City or Town, State
<u>Rosedale, Md</u> | | |
| | 21. Signature of Funeral Service Licensee
<u>Kevita S. Wells</u> | | | | 22. Name and Address of Facility
<u>Evans Funeral Chapel
8800 Harford Rd Baltimore, Md 21234</u> | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| | <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>MASSIVE RIGHT INTRA-CEREBRAL HEMORRHAGE</u></p> <p>Due to (or as a consequence of):</p> <p>b. <u>HYPERTENSION</u></p> <p>Due to (or as a consequence of):</p> <p>c.</p> <p>Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 35%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><u>1 DAY</u></p> </div> </div> | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
<u>Joginder M. Mehta M.D.</u> | | | | 29c. License number
<u>D 41410</u> | | 29d. Date signed (Month, Day, Year)
<u>May 30th, 1999</u> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>JOGINDEE MEHTA M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204</u> | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<u>JUN 3 1999</u> | | 32. Registrar's Signature
<u>B. Sparks</u> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

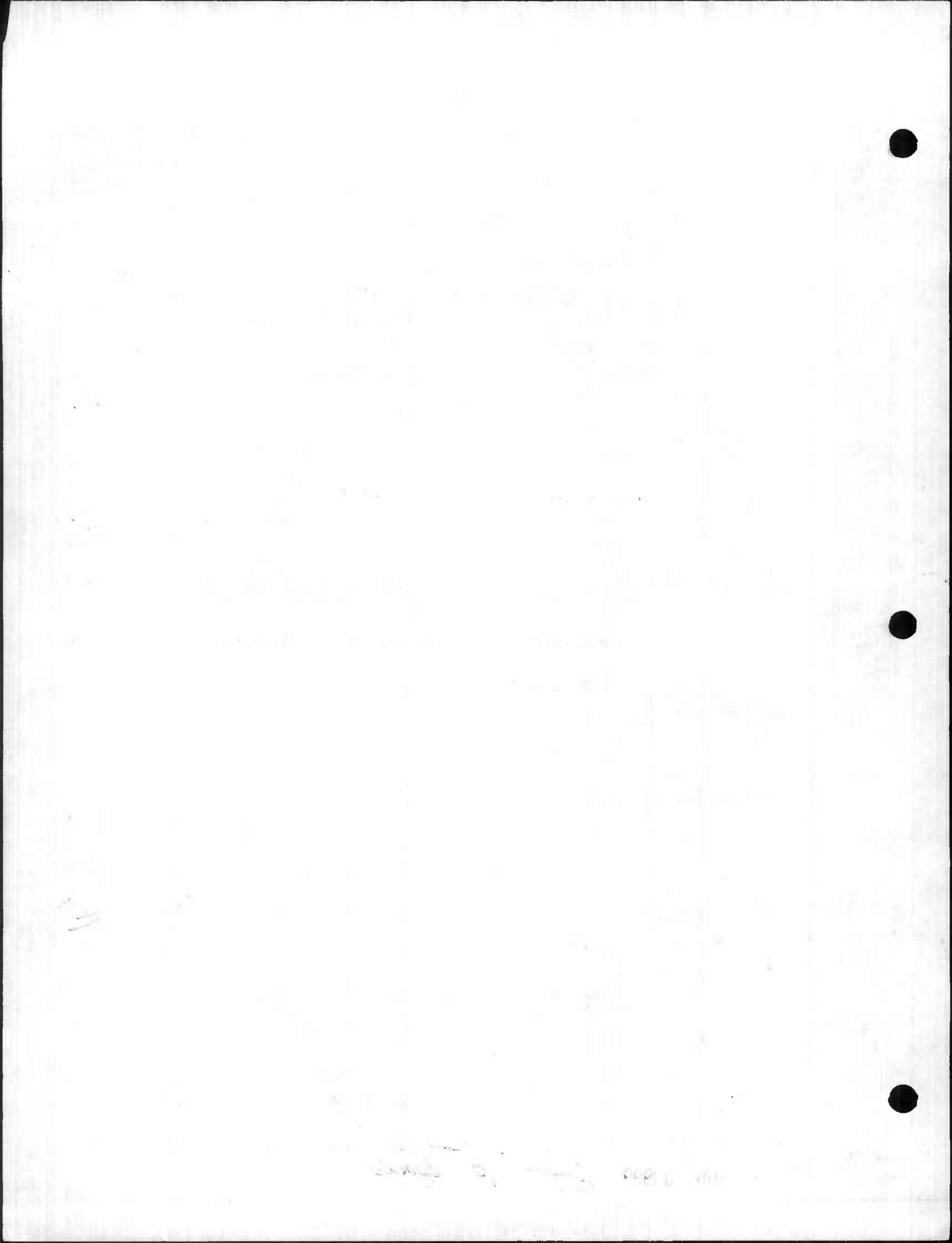
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17796

| | | | | | | | | |
|---|--|---|--|---|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WILLIAM DANIEL PEACHER | | | | 2. Date of Death
Month Day Year
May 25, 1999 | | 3. Time of Death
1345 | |
| | 4a. Facility Name (If not institution, give street and number)
Fallston General Hospital | | | | 4b. City, Town, or Location of Death
Fallston | | 4c. County of Death
Harford | |
| Funeral
Director | 5. Social Security Number
219-01-3174 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 9, 1920 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Harford | | 10c. City, Town or Location
Bel Air | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
3031 Lochary Road | | 10f. Zip Code
21015 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>
4 years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Proprietor | | 16b. Kind of Business/Industry
Home Builder/Developer | | | | |
| 17. Father's Name (First, Middle, Last)
Oliver Peacher | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Balbina Stahowski | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Jan R. Peacher (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3031 Lochary Road, Bel Air, MD. 21015 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Green Mount Crematory | | Data
5/29/99 | | 20c. Location - City or Town, State
Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee
Bruce A. Willem | | | | 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Road, Bel Air, MD. 21014 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CEREBRAL VASCULAR ACCIDENT
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. CORONARY ARTERY DISEASE
Due to (or as a consequence of):
c. PERIPHERAL VASCULAR DISEASE
Due to (or as a consequence of):
d. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
Edmund S. [Signature] | | | | 29c. License number
031775 | | 29d. Date signed (Month, Day, Year)
June 1, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joan P. Edwards, M.D. 2112 Belair Road, Fallston, Maryland 21047 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | 32. Registrar's Signature
[Signature] | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17797

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Tyreese Parker

2. Date of Death

Month
JuneDay
1Year
1999

3. Time of Death

12:08am

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

217-53-3442

6. Sex

M 2 ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

10

28

98

9. Birthplace (State or Foreign Country)

M.D.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2910 Garrison Blvd Apt 1B

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
naCollege (1-4 or 5+)
na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

na

16b. Kind of Business/Industry

na

17. Father's Name (First, Middle, Last)

McGregory Parker

18. Mother's Name (First, Middle, Maiden Surname)

Tonia Napier

19a. Informant's Name/Relationship (Type, Print)

Tonia Parker-Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2910 Garrison Blvd Apt 1B, Balto Md 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Park 6/5/99

Date

20c. Location - City or Town, State

Randallstown, Md

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

March F/H West
4300 Wabash Ave, Baltimore Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. pulmonary edema
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. renal failure
Due to (or as a consequence of):c. status post cardiopulmonary resuscitation
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

status post AV canal repair, VSD, pulmonary hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Rita Ongjoco, DO

29c. License number

H52231

29d. Date signed (Month, Day, Year)

June 1, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Rita Ongjoco, DO - Sinai Hospital of Baltimore

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17798

| | | | | | | | | |
|--|--|--------------------------|---|---|--|---|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>William Payne</i> | | | | 2. Date of Death
Month <i>May</i> Day <i>24</i> Year <i>1999</i> | | 3. Time of Death
<i>5:15 AM</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Sinai Hospital of Baltimore</i> | | | | 4b. City, Town, or Location of Death
<i>Baltimore</i> | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
<i>257-70-4216</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>52</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
<i>5-23-47</i> | 9. Birthplace (State or Foreign Country)
<i>Ga</i> |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
<i>MD</i> | | 10b. County
<i>WA</i> | | 10c. City, Town or Location
<i>Baltimore</i> | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
<i>3410 Lynchester Road</i> | | | | 10f. Zip Code
<i>21215</i> | | 10g. Citizen of What Country?
<i>U.S.A</i> | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>Black</i> | |
| 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12th grade</i> College (1-4or 5+) <i>1 year</i> | | | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
<i>Environmental Technician Waste Water</i> | | 16b. Kind of Business/Industry
<i>Baltimore city</i> | | |
| 17. Father's Name (First, Middle, Last)
<i>Thomas Marcus Payne</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Ruby Ballard</i> | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>Carol B. Payne - wife</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>3410 Lynchester Road Balto, md 21215</i> | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>King Memorial Park</i> | | Data
<i>5-28-99</i> | 20c. Location - City or Town, State
<i>Randallstown, md</i> | | |
| 21. Signature of Funeral Service Licensee
<i>Bladys Warner</i> | | | | 22. Name and Address of Facility
<i>March F.H. West 4300 Wabash Avenue Balto, md 21215</i> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. <i>Heart Failure</i>
Due to (or as a consequence of):
b. <i>Mitral valve endocarditis</i>
Due to (or as a consequence of):
c. <i>Mitral valve replacement, coronary</i>
Due to (or as a consequence of):
d. <i>artery bypass</i> | | | | | | | | Approximate Interval Between Onset and Death
<i>72 hours</i> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | |
| | | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29c. License number
<i>024726</i> | | | | |
| 29b. Signature and title of certifier
<i>A. Sequeira</i> | | | | 29c. License number
<i>024726</i> | | 29d. Date signed (Month, Day, Year)
<i>May/24/1999</i> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Alejandro Sequeira MD. Sinai Hospital of Baltimore</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>JUN 3 1999</i> | | | | 32. Registrar's Signature
<i>Geneva B. Sparks</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1041 A1A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17799

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Thelma Parker

2. Date of Death

May

Day

30, 1999

3. Time of Death

8:08 A.M.

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare of Caton Manor

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-03-8980

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

April 7, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3222 Magnolia Avenue

10f. Zip Code

21227

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Tailor Shop

17. Father's Name (First, Middle, Last)

William Hale

18. Mother's Name (First, Middle, Maiden Surname)

Alice Blondel

19a. Informant's Name/Relationship (Type, Print)

Richard Parker, Sr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3222 Magnolia Avenue Baltimore, Maryland 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Glen Haven Memorial Park 6/2/99 Glen Burnie, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Christina J. Hilton

22. Name and Address of Facility

McCully-Polyniak Funeral Home P.A.

237 E. Patapsco Avenue Baltimore, Maryland 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

Sepsis

Approximate Interval Between Onset and Death

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

infected decubitus

days

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

DR. OCHANEY MD

29c. License number

D-40521

29d. Date signed (Month, Day, Year)

June 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. OCHANEY

3350 WILKENS AVENUE SUITE 302

BALTIMORE, MD 21229

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17800

| | | | | | | | | |
|--|---|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Mary Grace Perrelli | | | | 2. Date of Death
Month Day Year
May 29, 1999 | | 3. Time of Death
3:30 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Frederick Villa Nursing Center | | | | 4b. City, Town, or Location of Death
Catonsville | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
216-36-7605 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
90 Yrs. | | 8. Date of Birth (Month, Day, Year)
Aug. 28, 1908 | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country)
Pennsylvania | | 10. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Dundalk | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
2415 Fairway | | | | 10f. Zip Code
21222 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 Years College (14 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | |
| | 17. Father's Name (First, Middle, Last)
Frank DeLuca | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Carmela Borrelli | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Robert W. Perrelli / Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13 Sunnymede Ct. Potomac, MD 20854-2663 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Stanislaus Cemetery 6/2/99 | | 20c. Location - City or Town, State
Dundalk, MD | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
Duda- Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <i>PNEUMONIA</i>
Due to (or as a consequence of):
b. <i>ASCVD</i>
Due to (or as a consequence of):
c. <i>CVA</i>
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>NO CODE</i> | | | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| State Registrar | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
<i>[Signature]</i> W.D. | | | | 29c. License number
12-19528 | | 29d. Date signed (Month, Day, Year)
6/1/99 | |
| | 30. Name and address of person who completed cause of death (Item 29a) (Type, Print)
ELMO M. GAYOSO 3411 OLD FREDERICK ROAD
BALTO. MD. 21229 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
JUN - 3 1999 | | | | 32. Registrar's Signature
<i>[Signature]</i> B. Sparks | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17801

| | | | | | | | | |
|---|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
William Howard Pick, Jr. | | | | 2. Date of Death
Month Day Year
05 28 1999 | | 3. Time of Death
2:30 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Johns Hopkins Bayview Medical Ctr. | | | | 4b. City, Town, or Location of Death
Baltimore City | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
219-28-5773 | | 6. Sex
XX M 2□ F | | 7. Age (In yrs. last birthday)
68 Yrs. | | 8. Date of Birth (Month, Day, Year)
03-16-1931 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Dundalk | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1□ Yes 2□ No | | 10e. Street and Number
3414 North Point Road | | 10f. Zip Code
21222 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
1□ Never Married 2□ Married
3□ Widowed 4□ Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1□ Yes 2□ No
If Yes, Give Year or Dates: Korean | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1□ Yes 2□ No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (14 or 5+)
G.E.D. | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Pressman | | 16b. Kind of Business/Industry
Printing | | | |
| | 17. Father's Name (First, Middle, Last)
William Howard Pick, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Not Known | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Lorraine D. Pick/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3414 North Pt. Road Dundalk, Maryland 21222 | | | |
| | 20a. Method of Disposition
1□ Burial 2□ Cremation 3□ Removal from State
4□ Donation 5□ Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Mem. Park | | 20c. Location - City or Town, State
Dorsey, Maryland | | 20d. Date
6/1/1999 | |
| | 21. Signature of Funeral Service Licensee
Patrick M. Heming | | | | 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1□ Yes 2□ No 3□ Probably 4□ Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
1□ Yes 2□ No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1□ Yes 2□ No | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1□ Yes 2□ No | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: 1□ Inpatient 2□ ER/Outpatient 3□ DOA Other: 4□ Nursing Home 5□ Residence 6□ Other (Specify) | | | | | | | |
| | 27. Manner of Death
1□ Natural 2□ Accident 3□ Suicide 4□ Homicide 5□ Pending Investigation 6□ Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1□ Yes 2□ No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1□ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier
Gail W. Miller, M.D. | | 29c. License number
D22719 | | 29d. Date signed (Month, Day, Year)
5/31/99 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GAIL W. MILLER, M.D. 1205 York Rd. Ste 38 Lutherville MD 21093 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
JUN - 3 1999 | | 32. Registrar's Signature
B. Sparks | | | | | |
| | State Registrar | | | | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17802

| | | | | | | | | |
|--|--|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Thomas Reilly | | | | 2. Date of Death
Month Day Year
May 27, 1999 | | 3. Time of Death
2:15 p.m. | |
| | 4a. Facility Name (If not institution, give street and number)
Country Gardens Assisted Living | | | | 4b. City, Town, or Location of Death
Highland | | 4c. County of Death
Howard | |
| Funeral
Director | 5. Social Security Number
182-24-2248 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
70 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 7, 1928 | |
| | 9. Birthplace (State or Foreign Country)
Pennsylvania | | 10a. State
MD | | 10b. County
Howard | | 10c. City, Town or Location
Highland | |
| 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
12752 Route 216 | | 10f. Zip Code
20777 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Telecommunication | | 16b. Kind of Business/Industry
Telephone | | | | |
| 17. Father's Name (First, Middle, Last)
William Reilly | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Brophy | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Margaret Lyman/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
46 E. Chelton Road, Parkside, Pennsylvania 19015 | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Washington Cr. | | 20c. Date
5/29/99 | | 20d. Location - City or Town, State
Laurel, Maryland | | |
| 21. Signature of Funeral Service Director
 | | | | 22. Name and Address of Facility
Fleck Funeral Home, Inc.
7601 Sandy Spring Road, Laurel, Maryland 20707 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. Coronary Heart Failure
Due to (or as a consequence of):</p> <p>b. CAD
Due to (or as a consequence of):</p> <p>c.
Due to (or as a consequence of):</p> <p>d.
Due to (or as a consequence of):</p> </div> </div> | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and Title of Certifier
 | | | | 29c. License number
Sc 1082039 | | 29d. Date signed (Month, Day, Year)
5/28/1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William J. Gault 18111 Prince Phillip Drive, #328, Olney, MD | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | 32. Registrar's Signature
 | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17803

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Pamela

Roberts

2. Date of Death

May 26 1999

3. Time of Death

5:10 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

218-58-9218

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

48

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Dec. 17, 1950

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3216 E. Fairmont Avenue

10f. Zip Code

21224

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Frederick William Smith

18. Mother's Name (First, Middle, Maiden Surname)

Alice Mary Davinson

19a. Informant's Name/Relationship (Type, Print)

Faye Kilgore (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14 Trout Lane, Stewartown, Pennsylvania 17363

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

5/29/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

David Yu, MD

22. Name and Address of Facility

Schmunek Funeral Home Inc.
3331 Brehms Lane, Baltimore, Maryland 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Out of hospital ventricular fibrillation

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Idiopathic cardiomyopathy

Due to (or as a consequence of):

Unknown

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David Yu, MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

May 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Yu, MD, Tower 110, Johns Hopkins Hospital, Baltimore, MD 21205

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

David B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17804

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Francis John Riedy

2. Date of Death

Month
MayDay
28,Year
1999

3. Time of Death

6:30 a.m.

4a. Facility Name (If not institution, give street and number)

3208 Polar Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

302-14-4451

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
July 8, 1925

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3208 Polar Avenue

10f. Zip Code

21227

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

police officer

16b. Kind of Business/Industry

Baltimore City Police
Department

17. Father's Name (First, Middle, Last)

Frank Theophile Riedy

18. Mother's Name (First, Middle, Maiden Surname)

Martha Mary Rill

19a. Informant's Name/Relationship (Type, Print)

Joyce Larsen - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

176 Oak Drive, Pasadena, Maryland 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Loudon Park Cemetery

Date

6/2/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Loudon Park Funeral Home
3620 Wilkens Avenue
Baltimore, Maryland 2122923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Non Small Cell Lung Carcinoma Stage IV six months

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

Inpatient hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D37196

29d. Date signed (Month, Day, Year)

06/01/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rosemarie Butler Field 6320 Ritchie Hwy Ste 1 Glen Burnie Md 21061

31. Date filed (Month, Day, Year)

JUN - 3 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17805

| | | | | | | | | |
|--|---|---|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Catherine V. Robinson</i> | | | | 2. Date of Death
Month <i>JUNE</i> Day <i>1</i> Year <i>1999</i> | | 3. Time of Death
<i>7:24 Am</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Bon Secours Hospital</i> | | | | 4b. City, Town, or Location of Death
<i>Baltimore</i> | | 4c. County of Death
<i>N/A</i> | |
| Funeral
Director | 5. Social Security Number
<i>216-20-9146</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>73</i> Yrs. | | 8. Date of Birth (Month, Day, Year)
<i>MAR 12 1926</i> | |
| | 9. Birthplace (State or Foreign Country)
<i>MARYLAND</i> | | 10e. State
<i>MARYLAND</i> | | 10b. County
<i>N/A</i> | | 10c. City, Town or Location
<i>BALTIMORE CITY</i> | |
| To Be Completed by Funeral Director | 10e. Street and Number
<i>1100 PENNSYLVANIA AVENUE APT 506</i> | | | | 10f. Zip Code
<i>21201</i> | | 10g. Citizen of What Country?
<i>U.S.A.</i> | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>BLACK</i> | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>unknown</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>DIETARY DEPARTMENT</i> | | 16b. Kind of Business/Industry
<i>UNIVERSITY HOSPITAL</i> | | | |
| | 17. Father's Name (First, Middle, Last)
<i>WALTER LIGGINS</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>MARY LIGGINS</i> | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>Brenda M. Taylor/Daughter</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>4705 Marling Rd, Baltimore, Maryland 21208</i> | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>GARRISON FOREST</i> | | 20c. Location - City or Town, State
<i>6-7-99 OWINGS MILLS, MARYLAND</i> | | | |
| | 21. Signature of Funeral Service Licensee
<i>William C Brown</i> | | | | 22. Name and Address of Facility
<i>WILLIAM C BROWN COMMUNITY FUNERAL HOME PA
1206 W NORTH AVENUE</i> | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>a. Acute Myocardial infarction</i>
Due to (or as a consequence of):
<i>b. Atherosclerotic Cardiovascular Disease</i>
Due to (or as a consequence of):
<i>c.</i>
Due to (or as a consequence of):
<i>d.</i> | | | | | | | |
| | Approximate Interval Between Onset and Death
<i>12 Hrs</i>
<i>not known</i> | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.
<i>Diabetes mellitus</i> | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Manuel Garcia MD</i> | | 29c. License number
<i>D15698</i> | | 29d. Date signed (Month, Day, Year)
<i>June 1, 1999</i> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>MARCOS GALICIA MD Bon Secours Hosp, Baltimore, Md 21223</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>JUN - 3 1999</i> | | 32. Registrar's Signature
<i>B. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17806

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Skane

2. Date of Death

May 20th 1999

3. Time of Death

1:45 AM

4a. Facility Name (If not Institution, give street and number)

Bon Secours Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

218-98-4564

6. Sex

M 2 F

7. Age (In yrs. last birthday)

33

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

August 22, 1965

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

2223 W. Pratt Street

10f. Zip Code

21223

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Construction Worker

16b. Kind of Business/Industry

Construction Company

17. Father's Name (First, Middle, Last)

Joseph Kenneth Skane

18. Mother's Name (First, Middle, Maiden Surname)

Bonnie Lee Engelskirch

19a. Informant's Name/Relationship (Type, Print)

Joseph K. Skane / Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7233 Bridgewood Drive Baltimore, Maryland 21224

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lakeview Memorial Park

Date

6/2/99

20c. Location - City or Town, State

Sykesville, Maryland

21. Signature of Funeral Service Licensee

Quanta R Thomas

22. Name and Address of Facility

Hubbard Funeral Home, Inc.
4107 Wilkens Avenue Baltimore, Maryland 2122923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Anoxic Encephalopathy

9 days

Due to (or as a consequence of):

b. Bilateral Pneumonia

8 days

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy
performed?

1 Yes 2 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 Yes 2 No

25. Was case referred to medical
examiner?
1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

26. Place of Death (Check only one)

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending
2 Accident Investigation
3 Suicide 6 Could not be
4 Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Quanta R Thomas MD

medical
Attending

29c. License number

D38993

29d. Date signed (Month, Day, Year)

5/29/99.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Quanta R Thomas

2600 Liberty Heights Baltimore MD 21215.

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

Quanta R Thomas

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10. 1. 1900

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 21st inst. in relation to the above matter.
The same has been forwarded to the proper authorities for their consideration.
I am, Sir, very respectfully,
Yours obedient servant,
J. H. [Signature]

Very truly yours,
J. H. [Signature]
[Faint text and signature at the bottom of the page]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17807

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

| | | | | | | | | | |
|---|--|---|---|--|--------------------------------|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
Robert Joseph Shaw | | | | 2. Date of Death
Month Day Year
MAY 31, 1999 | | | | 3. Time of Death
11:30 PM | |
| 4a. Facility Name (If not institution, give street and number)
ROUTE 50 near CHURCH ROAD | | | | 4b. City, Town, or Location of Death
Bowie | | | | 4c. County of Death
PRINCE GEORGES | |
| 5. Social Security Number
224-49-1892 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
19 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Jan. 21, 1980 | | 9. Birthplace (State or Foreign Country)
Virginia | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Virginia | | 10b. County
Fairfax | | 10c. City, Town or Location
Springfield | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
8491 Magic Tree Court | | | | 10f. Zip Code
22153 | | 10g. Citizen of What Country?
U.S.A. | | | |
| 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th. Grade
College (14 or 5+) College (14 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Student | | | 16b. Kind of Business/Industry
Education | | |
| 17. Father's Name (First, Middle, Last)
Edward A. Shaw | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Linda S. Blanchard | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Linda S. Shaw/Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8491 Magic Tree CT Springfield VA 22153 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
National Memorial Park | | Date
6/4/99 | | 20c. Location - City or Town, State
Falls Church VA | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Charles S. Zeiler & Son, Inc.
6224 Eastern Ave Baltimore MD 21224 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Multiple Injuries
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
5/31/99 | | 28b. Time of Injury
1123 M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
Pedestrian struck by auto | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Freeway | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Rte. 50/Church Rd. | | | | | | | |
| 29a. Certifier (Check only)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
OCME | | | 29d. Date signed (Month, Day, Year)
JUNE 01, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | 32. Registrar's Signature
 | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17808

| | | | | | | | | |
|---|---|---|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Teddyanne Schoo | | | | 2. Date of Death
Month Day Year
MAY 30, 1999 | | 3. Time of Death
12:44 PM | |
| | 4a. Facility Name (If not institution, give street and number)
JOHN HOPKINS BAYVIEW | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
215-40-9854 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
53 55 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Oct. 7, 1943 | | 9. Birthplace (State or Foreign Country)
Md. |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Md. | | 10b. County
Baltimore | | 10c. City, Town or Location
Dundalk | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
10 Liberty Parkway | | | | 10f. Zip Code
21222 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Operator | | | 16b. Kind of Business/Industry
Telephone | |
| 17. Father's Name (First, Middle, Last)
Chester Fields | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Anne Marie Barker | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
James Schoo/ Stepson | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10 Liberty Pkwy., Dundalk, Md. 21222 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
OakLawn Cemetery | | Date
6-2-99 | | 20c. Location - City or Town, State
Balto., Md. | | |
| 21. Signature of Funeral Service Licensee
Edison H. Perkins | | | | 22. Name and Address of Facility
Bradley-Ashton-Matthews Funeral Home, Inc.
2134 Willow Spring Rd., Balto., Md. 21222 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic cardiovascular disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. _____ Due to (or as a consequence of):
c. _____ Due to (or as a consequence of):
d. _____ | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
Yes
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Thayne Dreyer | | | | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
MAY 31, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Thayne Dreyer 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | 32. Registrar's Signature
Thayne Dreyer | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

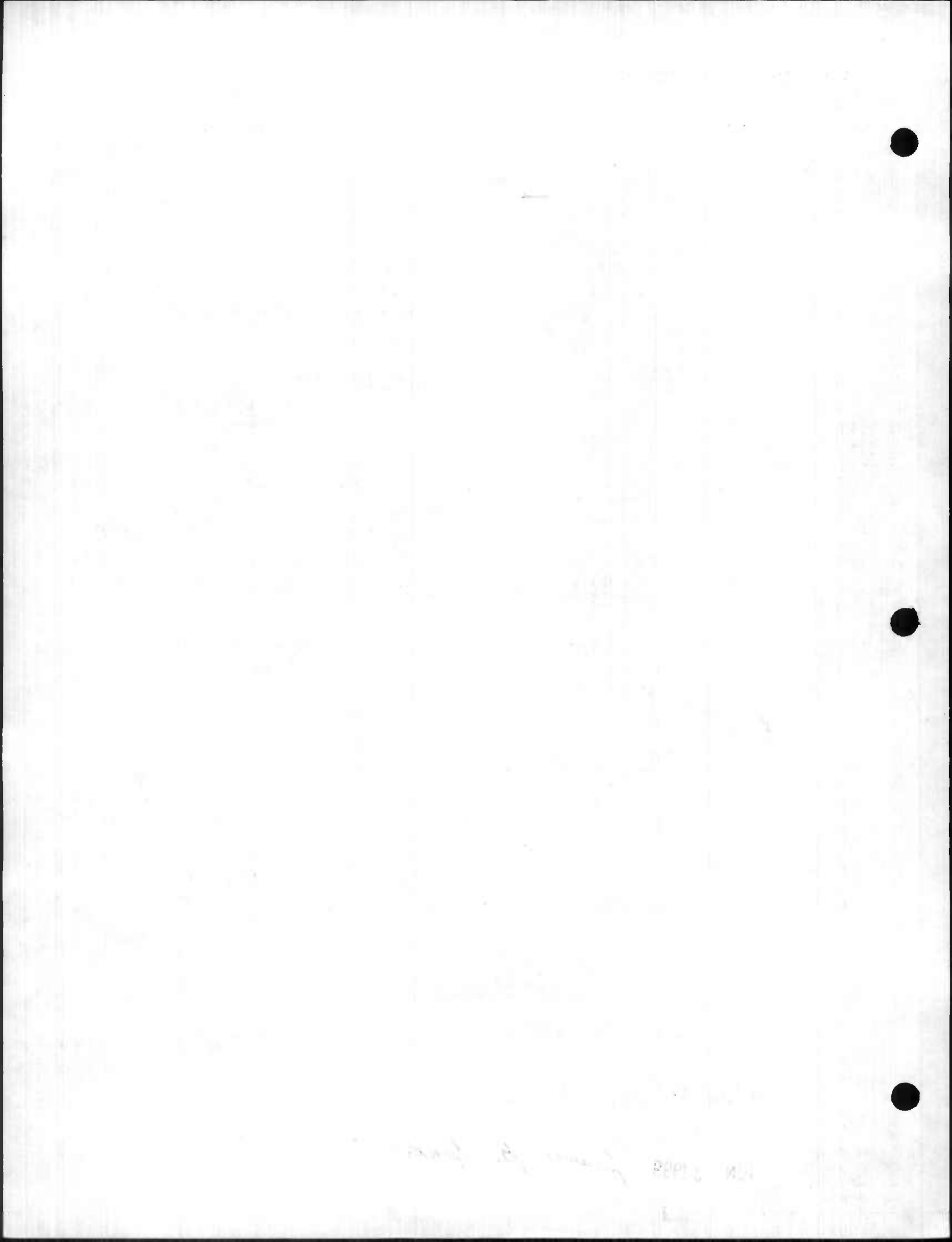
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17809

Physician
/Medical
Examiner

Funeral
Director

| | | | | |
|---|--|---|--|---|
| 1. Decedent's Name (First, Middle, Last)
<i>Pearl Sharp</i> | | 2. Date of Death
Month <i>May</i> Day <i>27</i> Year <i>1999</i> | | 3. Time of Death
<i>1745</i> |
| 4a. Facility Name (If not institution, give street and number)
<i>Bon Secours Hosp.</i> | | 4b. City, Town, or Location of Death
<i>Balto</i> | | 4c. County of Death
<i>N/A</i> |
| 5. Social Security Number
<i>217-14-1857</i> | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>77</i> Yrs. | 8. Date of Birth (Month, Day, Year)
<i>JULY 3, 1921</i> | 9. Birthplace (State or Foreign Country)
<i>Maryland</i> |
| Usual Residence of Decedent | | | | |
| 10a. State
<i>MD</i> | 10b. County
<i>N/A</i> | 10c. City, Town or Location
<i>Baltimore</i> | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number
<i>123 S. Payson St.</i> | | 10f. Zip Code
<i>21223</i> | | 10g. Citizen of What Country?
<i>USA</i> |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc.
Specify: <i>white</i> | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>8</i> Collega (1-4or 5+) | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Homemaker</i> | | 16b. Kind of Business/Industry
<i>Own Home</i> | | |
| 17. Father's Name (First, Middle, Last)
<i>Elmer Matthews</i> | | 18. Mother's Name (First, Middle, Maiden Summa)
<i>Pearl (Unavailable)</i> | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>Willard Lee Sharp - husband</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>123 S. Payson St., Balto., Md. 21223</i> | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Lorraine Park Cemetery</i> | | 20c. Location - City or Town, State
<i>Baltimore, Md.</i> |
| 21. Signature of Funeral Service Licensee
<i>Thomas L. Kaufman</i> | | 22. Name and Address of Facility
<i>Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc
7250 Washington Blvd., Elkridge, Md. 21075</i> | | |
| 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<i>ACUTE MYOCARDIAL INFARCTION</i>
Due to (or as a consequence of):
<i>CORONARY ARTERY DISEASE</i>
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<i>M</i> |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| 29b. Signature and title of certifier
<i>Edward Belgiano MD</i> | | 29c. License number
<i>D31993</i> | | 29d. Date signed (Month, Day, Year)
<i>June 01, 1999</i> |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>EDWARD BELGIANO 2000 W. BALTIMORE ST</i> | | | | |
| 31. Date filed (Month, Day, Year)
<i>JUN 3 1999</i> | | 32. Registrar's Signature
<i>B. Sparks</i> | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17810

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ZELDA SAMPLE | | | | 2. Date of Death
Month Day Year
May 17 1999 | | 3. Time of Death
7:46 | |
| | 4a. Facility Name (If not institution, give street and number)
Univ. of Maryland Medical Center | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
221-40-3120 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
41 Yrs. | | 8. Date of Birth (Month, Day, Year)
11/1/57 | |
| | 9. Birthplace (State or Foreign Country)
LEWES DEL | | 10a. State
DEL | | 10b. County
SUSSEX | | 10c. City, Town or Location
MILLSBORO | |
| To Be Completed by Funeral Director | 10a. Street and Number
LOT 20 COLONIAL EST. | | | | 10f. Zip Code
19966 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
FACTORY | | 16b. Kind of Business/Industry
POULTRY PLANT | | | |
| | 17. Father's Name (First, Middle, Last)
CURTIS CAESAR | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ADA WAPLES | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
SIDNEY SAMPLE HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
LOT 20 COLONIAL EST MILLSBORO DE 19966 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
PEOPLE MEMORIAL PARK | | Date
5/18/99 | | 20c. Location - City or Town, State
Midway Lewes DEL | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
<i>Charles E. Young</i> | | | | 22. Name and Address of Facility
Youngs Funeral Home 309 North Street
Milford Del. 19963 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. MASSIVE HEMOPTYSIS
Due to (or as a consequence of)

b. LEFT UPPER LOBE PULMONARY ASPERGILLOSA
Due to (or as a consequence of)

c. PULMONARY SARCOID
Due to (or as a consequence of)

d. | | | | Approximate Interval Between Onset and Death | | | |
| Division of Vital Records, P.O. Box 68760, | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| State Registrar | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Thom...</i> | | 29c. License number
P11771 | | 29d. Date signed (Month, Day, Year)
MAY 17, 1999 | |
| To Be Completed by Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THOMAS HARRISON 22 SOUTH GREENE ST. BALTO, MD 21201 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
JUN 3 1999 | | 32. Registrar's Signature
<i>Benjamin B. Sparks</i> | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17811

| | | | | | | | | |
|--|---|---|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ODESSA LAVERNE SCOTT | | | | 2. Date of Death
Month May Day 31st Year 1999 | | 3. Time of Death
9:45pm | |
| | 4a. Facility Name (If not institution, give street and number)
North Arundel Hosp | | | | 4b. City, Town, or Location of Death
Glen Burnie | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
212-52-3857 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
60 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
APRIL 5, 1939 | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | | 10b. County
A. A. County | | 10c. City, Town or Location
GLEN BURNIE | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
2 PHYLLIS DRIVE | | | | 10f. Zip Code
21060 | | 10g. Citizen of What Country?
USA. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed)
11th GRADE | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CUSTODIAN | | 16b. Kind of Business/Industry
A.A. Co. PUBLIC SCHOOLS | |
| | 17. Father's Name (First, Middle, Last)
RICHARD H. EDWARDS | | | | 18. Mother's Name (First, Middle, Maiden Surname)
SARAH E. PEARMAN | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
RICHARD EDWARDS (FATHER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
332 KESS CIRCLE, GLENBURNIE MD. 21060 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
PINELAWN MEMORIAL PARK | | Date
06-04-99 | | 20c. Location - City or Town, State
ANNAPOLIS, MARYLAND | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE. BALTIMORE, MD. 21217 | | | |
| | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
SEPSIS | | | | | | | |
| | 23b. Approximate Interval Between Onset and Death
Three days | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
End-stage Renal Failure,
Cardiomyopathy | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
 MD | | | | 29c. License number
1D48006 | | 29d. Date signed (Month, Day, Year)
May 31st, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KOFI BONIFEY, 301 Hosp. Dr, Glen Burnie, MD 21061 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

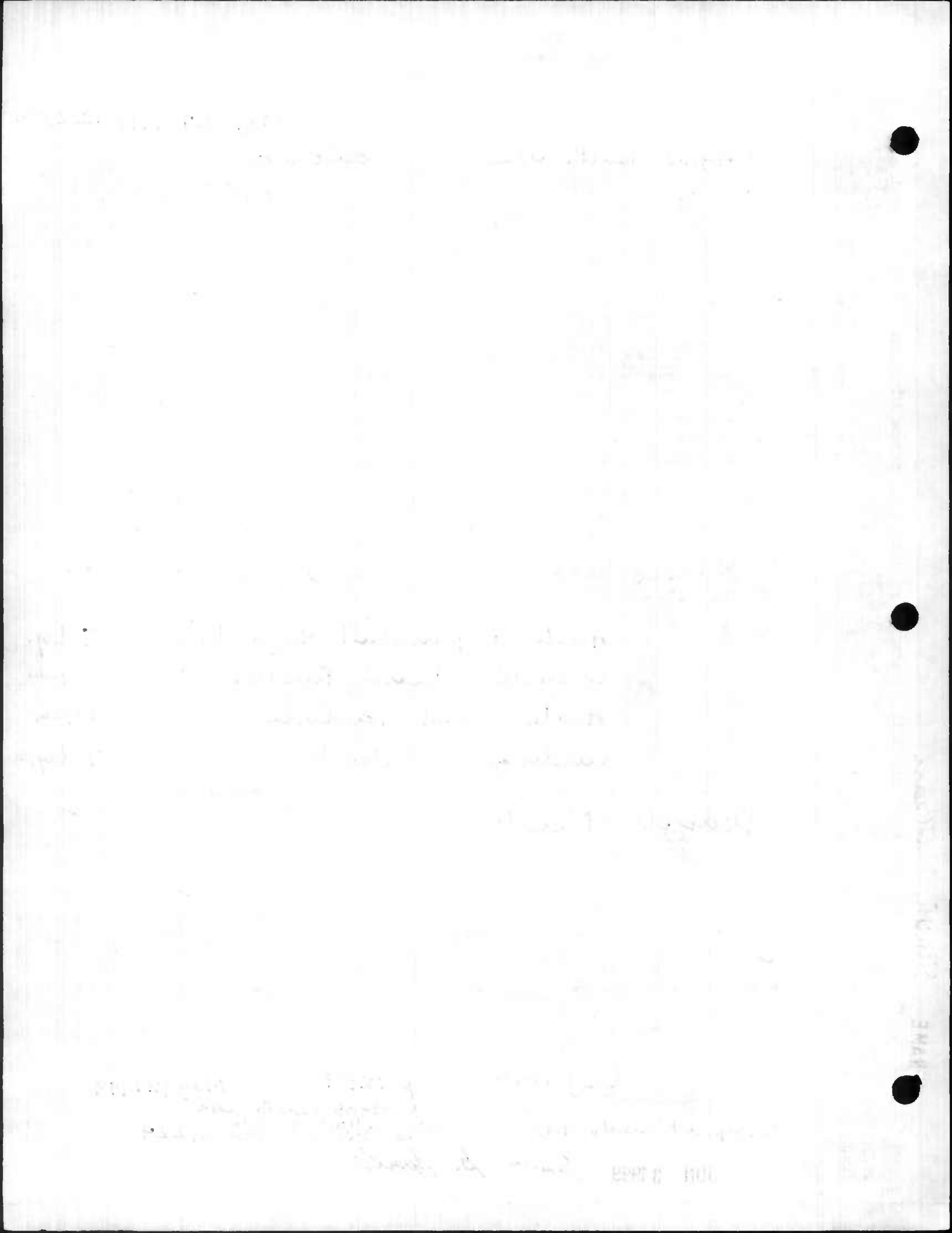
99 17812

| | | | | | | | | | |
|---|---|---------------------------------------|---|---|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Elease Smith | | | | 2. Date of Death
Month May Day 27 Year 1999 | | 3. Time of Death
12.25 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
St Agnes health care | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death | | |
| Funeral
Director | 5. Social Security Number
215-05-3900 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
90 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
07 15 08 | 9. Birthplace (State or Foreign Country)
S.C. | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
320 Gwynn Ave | | | | 10f. Zip Code
21229 | | 10g. Citizen of What Country?
U.S.A | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7th grade
College (1-4 or 5+) na | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Cafeteria | | 16b. Kind of Business/Industry
Baltimore City Sch | | | |
| 17. Father's Name (First, Middle, Last)
Lee Davis | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ella | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Dorothy Garvin-Niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
318 Gwynn Ave, Baltimore Md 21229 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus Memorial Park 6/3/99 Arbutus, Md | | | 20c. Location - City or Town, State | | | |
| 21. Signature of Funeral Service Licensee
Bladys W... | | | | 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Acute Myocardial infarction Due to (or as a consequence of): 7 day
b. Congestive heart Failure Due to (or as a consequence of): 10 years
c. Acute renal Failure Due to (or as a consequence of): 10 years
d. Cardiogenic shock Due to (or as a consequence of): 7 day | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
Mustapha M. D. | | 29c. License number
P12595 | | 29d. Date signed (Month, Day, Year)
May 27/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mustapha Mallah, M.D. | | | | St Agnes health care
900 Canton Avenue
Baltimore, MD 21229 | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | | 32. Registrar's Signature
B. Sparks | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17812

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Margaret Schneider 2. Date of Death Month June Day 1 Year 1999 3. Time of Death 1:45 AM

4a. Facility Name (If not institution, give street and number) Manor Care Ruxton 4b. City, Town, or Location of Death Ruxton 4c. County of Death Baltimore

Funeral
Director

5. Social Security Number 216-12-0891 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) 76 Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 11, 1922 9. Birthplace (State or Foreign Country) Md.

Usual Residence of Decedent 10a. State Md. 10b. County Baltimore 10c. City, Town or Location Towson 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 722 Camberly Cr. Apt. B2 10f. Zip Code 21204 10g. Citizen of What Country? USA

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (14 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Printing Dept. 16b. Kind of Business/Industry U.S.F.&G.

17. Father's Name (First, Middle, Last) Francis T. Canter 18. Mother's Name (First, Middle, Maiden Surname) Jane Martin

19a. Informant's Name/Relationship (Type, Print) Mr. Stephen Schneider/son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Theo Lane Towson, Md. 21204

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Veterans Cem. Data 6/7/99 20c. Location - City or Town, State Owings Mills, Md.

21. Signature of Funeral Service Licensee [Signature] 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Polycythemia Vera. Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 28. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be determined 28e. Date of Injury (Month, Day Year) 28f. Time of Injury M 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier [Signature] 29c. License number D95475 29d. Date signed (Month, Day, Year) 6-1-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Rahnama, M.D. 17 Fontana Lane Baltimore, Md.

31. Date filed (Month, Day, Year) JUN - 3 1999 32. Registrar's Signature [Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Handwritten signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17814

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Clarence G. Scripture

2. Date of Death
Month Day Year
May 31 1999

3. Time of Death
12:25 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

506-18-0136

6. Sex

1X M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug 3, 1918

9. Birthplace (State or Foreign Country)

NE

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1745 Drexel Rd

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bricklayer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Grant Scripture

18. Mother's Name (First, Middle, Maiden Surname)

Frances Burda

19a. Informant's Name/Relationship (Type, Print)

Thelma Scripture /wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1745 Drexel Rd Baltimore, Md 21222

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

June 3 1999

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

Anthony C. Connelly

22. Name and Address of Facility

Connolly Funeral Home of Dundalk
7110 Sollers Point Rd 21222

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Esophageal Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sam Shivananda MD

29c. License number

D52379

29d. Date signed (Month, Day, Year)

5/31/99

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

DR. Savitha Shivananda 9000 Franklin Square Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

JUN - 3 1999

32. Registrar's Signature

James G. Sparks

State
Registrar

Scripture, Clarence Grant

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ATX 6071

99-3066-005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

BRIAN

State of Maryland / Department of Health and Mental Hygiene

SHOWALTER

Certificate of Death

Reg. No.

99 17815

| | | | | | | | | | |
|--|--|---|--|---|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Brian D. Showalter | | | | 2. Date of Death
Month Day Year
MAY 27, 1999 | | 3. Time of Death
6:45 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
28 SYLVAN PARK COURT | | | | 4b. City, Town, or Location of Death
Perry Hall | | 4c. County of Death
BALTIMORE | | |
| Funeral
Director | 5. Social Security Number
216-11-8104 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
20 Yrs. | | 8. Date of Birth (Month, Day, Year)
Nov. 4, 1978 | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Md. | | 10b. County
Baltimore | | 10c. City, Town or Location
Perry Hall | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
28 Sylvan Park Court | | 10f. Zip Code
21236 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Giant Food | | 16b. Kind of Business/Industry
Food Services | | | | | |
| 17. Father's Name (First, Middle, Last)
Barry Showalter | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Cynthia Kelly | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Cynthia Showalter/Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
28 Sylvan Park Ct. Perry Hall, Maryland 21236 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem. Grd. | | Data
6/1/99 | | 20c. Location - City or Town, State
Timonium, Maryland | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc.
1050 York Road Towson, Maryland 21204 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | a. <u>Hanging</u>
Due to (or as a consequence of): | | b.
Due to (or as a consequence of): | | c.
Due to (or as a consequence of): | | d.
Due to (or as a consequence of): | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
Fornel 5-27-99 | | 28b. Time of Injury
Fornel 1840 P M | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
subject hanged self | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
home | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
28 Sylvan Park Ct Baltimore Co., Md | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 28, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute | | 31. Data filed (Month, Day, Year)
JUN - 3 1999 | | 32. Registrar's Signature
 | | 111 Penn Street, Baltimore, Maryland 21201 | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

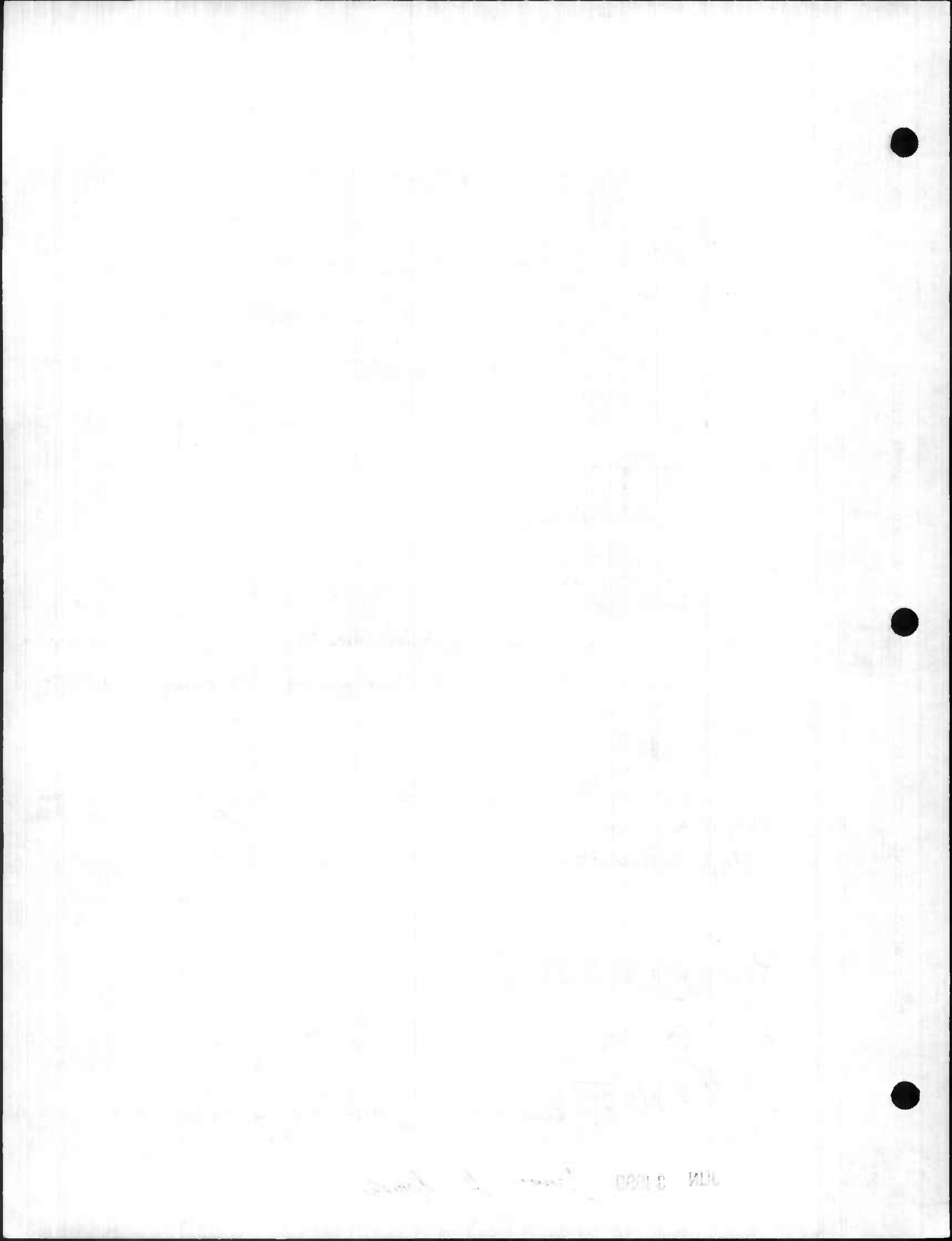
Reg. No.

99 17816

| | | | | | | | | |
|---|--|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Ruth Frances Sibalik</i> | | | | 2. Date of Death
Month <i>May</i> Day <i>29</i> Year <i>1999</i> | | 3. Time of Death
<i>8:00 AM</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>9675 Dixon Avenue</i> | | | | 4b. City, Town, or Location of Death
<i>Carney</i> | | 4c. County of Death
<i>Baltimore</i> | |
| Funeral
Director | 5. Social Security Number
<i>236-52-8176</i> | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>64</i> Yrs. | | 8. Date of Birth (Month, Day, Year)
<i>May 10, 1935</i> | |
| | 9. Birthplace (State or Foreign Country)
<i>West Virginia</i> | | 10a. State
<i>Maryland</i> | | 10b. County
<i>Baltimore</i> | | 10c. City, Town or Location
<i>Carney</i> | |
| To Be Completed by Funeral Director | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12th Grade</i> College (1-4 or 5+) | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Homemaker</i> | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
<i>Harry E. Robinson</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Sarah Amelia Shaw</i> | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>Mrs. Maria C. Ruley (daughter)</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>9675 Dixon Avenue, Carney, MD 21234</i> | | | |
| Physician
/Medical
Examiner | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>St. Joseph Church Cem.</i> | | 20c. Location - City or Town, State
<i>Baltimore, Maryland</i> | |
| | 21. Signature of Funeral Service Licensee
<i>Benjamin C. Williams</i> | | | | 22. Name and Address of Facility
<i>Schimunek Funeral Home, Inc.
9705 Belair Rd., Baltimore, MD 21236</i> | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <i>Sudden cardiac death</i>
Due to (or as a consequence of):
b. <i>Chronic Obstructive Lung Disease</i>
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death
<i>Immediate</i>
<i>years</i> | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Hypertension</i>
<i>Hypertension</i> | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year)
<i>NA</i> | | 28b. Time of Injury
<i>M</i> | |
| | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
<i>Albert E. De Loskey MD</i> | | | |
| To Be Completed by Physician/Medical Examiner | 29c. License number
<i>D23829</i> | | | | 29d. Date signed (Month, Day, Year)
<i>6/1/99</i> | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>515 Parkmont Ave Suite 330 Towson, MD 21286</i> | | | | 31. Date filed (Month, Day, Year)
<i>JUN 3 1999</i> | | | |
| State Registrar | 32. Registrar's Signature
<i>M. Sparks</i> | | | | 33. Date of Death (Month, Day, Year)
<i>May 29, 1999</i> | | | |

ORIGINAL



| | | | | | | | | |
|---|--|---|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
PATRICIA M. SNYDER | | | | 2. Date of Death
Month Day Year
MAY 27, 1999 | | 3. Time of Death
8:45 AM | |
| | 4a. Facility Name (If not institution, give street and number)
2302 Cool Woods Court | | | | 4b. City, Town, or Location of Death
Jarrettsville | | 4c. County of Death
Harford | |
| Funeral
Director | 5. Social Security Number
214-72-7181 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
41 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
March 9, 1958 | 9. Birthplace (State or Foreign Country)
Germany |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Harford | | 10c. City, Town or Location
Jarrettsville | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
2302 Cool Woods Court | | | | 10f. Zip Code
21084 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 years College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
C.P.A. | | 16b. Kind of Business/Industry
Accounting | | |
| 17. Father's Name (First, Middle, Last)
Richard Soper | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Eirich | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
R. Bruce Snyder, Sr. (Husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2302 Cool Woods Court, Jarrettsville, MD. 21084 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Highview Mem. Gardens | | Date
6/1/99 | | 20c. Location - City or Town, State
Fallston, Maryland | | |
| 21. Signature of Funeral Service Licensee
Mark T. Ziegen | | | | 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Road, Bel Air, MD. 21014 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)
a. OSIROSARCOMA PROBABLY RADIATION INDUCED | | | | | | | | 7 MONTHS |
| Due to (or as a consequence of):
b. Metastatic Breast Cancer | | | | | | | | 7 1/2 years |
| Due to (or as a consequence of):
c. | | | | | | | | |
| Due to (or as a consequence of):
d. | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Dr. P. Soper, Staff Physician | | | | 29c. License number
019714 | | 29d. Date signed (Month, Day, Year)
5/28/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MICHAEL P. JAMES, JR. 4940 RIVER AVE BALTIMORE MD 21224 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | 32. Registrar's Signature
James B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

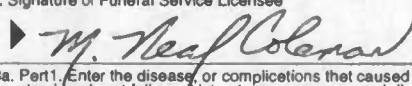
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17818

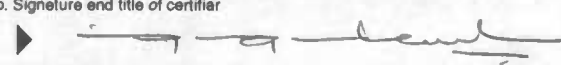

| | | | | | |
|---|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
FRANCIS X STUBLER | | 2. Date of Death
Month 05 Day 31 Year 1999 | | 3. Time of Death
02:02AM |
| | 4a. Facility Name (If not institution, give street and number)
GOOD SAMARITAN HOSPITAL, BALTIMORE MD | | 4b. City, Town, or Location of Death
MD | | 4c. County of Death
21289 |
| Funeral
Director | 5. Social Security Number
216-56-6341 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
48 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
2/26/51 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE CITY | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
1700 MERIDENE DRIVE | | | 10f. Zip Code
21239 | | 10g. Citizen of What Country?
USA |
| 11. Marital Status
<input type="checkbox"/> Navar Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: VIETNAM | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th GRADE
College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
LANDSCAPER | | 16b. Kind of Business/Industry
LANDSCAPING |
| 17. Father's Name (First, Middle, Last)
NORMAN J. STUBLER | | | 18. Mother's Name (First, Middle, Maiden Surname)
LEONA FULLER | | |
| 19a. Informant's Name/Relationship (Type, Print)
CHARLES STUBLER BROTHER | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1700 MERIDENE DRIVE BALTIMORE, MD 21239 | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GARRISON FOREST VET. CEM. | | 20c. Location - City or Town, State
OWINGS MILLS, MD | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
THE JOHNSON FUNERAL HOME, P.A.
8521 LOCH RAVEN BLVD. TOWSON, MD 21286 | | | |
| 23a. Pertinent disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
SEP SIS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
STROKE
CEREBRAL EDEMA
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | Approximate Interval Between Onset and Death
15 days |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HEPATIC ENCEPHALOPATHY
STROKE
CEREBRAL EDEMA | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
P-R 556 | | 29d. Date signed (Month, Day, Year)
MAY 31, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
AJAY CHAWLA, MD, GOOD SAMARITAN HOSPITAL, 1000 RAVEN BLVD, BALTIMORE, MD | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 3 1999 | | 32. Registrar's Signature
 | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 303-58.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

99-3062-510

PAUL

STASZKIEWICZ ITEMS: #23 PART I, 27 PER MEO G772 6-14-99

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17819

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | | | | | | |
|---|------------------------------|--|--|--|---|---|---------------------|--|--|------------------------------|----|----|
| 1. Decedent's Name (First, Middle, Last)
Paul Victor Staszkievicz | | 2. Date of Death
Month MAY Day 27 , Year 1999 | | 3. Time of Death
5:10P.M. | | | | | | | | |
| 4a. Facility Name (If not institution, give street and number)
1116 STEELTON AVE | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | | | | | | | |
| 5. Social Security Number
216-72-5442 | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
41 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sept. 6, 1957 | | | | | | | |
| 9. Birthplace (State or Foreign Country)
England | | | | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore City | | | | | | | | |
| 10d. Inside City Limits
1 Yes 2 No | | | | | | | | | | | | |
| 10e. Street and Number
1116 Steelton Avenue | | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
United States | | | | | | | |
| 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: | | | | | | | | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Retail | | 16b. Kind of Business/Industry
Automobile Parts | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
Walter Staszkievicz | | 18. Mother's Name (First, Middle, Maiden Surname)
Stefania Gonczarewski | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Lily Young / Sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
110 South Shaffer Drive New Freedom, PA 17349 | | | | | | | | | | |
| 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery | | 20c. Location - City or Town, State
Baltimore, Maryland | | | | | | | | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. CIRRHOSIS</td> <td rowspan="4"> Due to (or as a consequence of):

 Due to (or as a consequence of):

 Due to (or as a consequence of):

 Due to (or as a consequence of): </td> <td rowspan="4"> Approximate Interval Between Onset and Death </td> </tr> <tr> <td>b. CHRONIC ALCOHOLISM</td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table> | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. CIRRHOSIS | Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | Approximate Interval Between Onset and Death | b. CHRONIC ALCOHOLISM | c. | d. |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. CIRRHOSIS | Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | Approximate Interval Between Onset and Death | | | | | | | | | |
| | b. CHRONIC ALCOHOLISM | | | | | | | | | | | |
| | c. | | | | | | | | | | | |
| | d. | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | | | | | | | | |
| | | | | 24a. Was an autopsy performed?
1 Yes 2 No | | | | | | | | |
| | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | | | | | | | | |
| 25. Was case referred to medical examiner?
1 Yes 2 No | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | | | | | | | |
| | | 28c. Injury at Work?
1 Yes 2 No | | 28d. Describe how injury occurred | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 28, 1999 | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis Chute, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | 32. Registrar's Signature
 | | | | | | | | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17820

| | | | | | | | | | | |
|---|---|--------------------------|---|--|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Elizabeth B. Terrence | | | | | 2. Date of Death
Month May Day 28 Year 1999 | | 3. Time of Death
5:15 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
St. Martin's Home | | | | | 4b. City, Town, or Location of Death
Catonsville | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
062-05-0843 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
90 Yrs. | | 8. Date of Birth (Month, Day, Year)
February 3, 1909 | | 9. Birthplace (State or Foreign Country)
New York | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Catonsville | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
601 Maiden Choice Lane | | | | | 10f. Zip Code
21228 | | 10g. Citizen of What Country?
United States | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th Grade
College (1-4 or 5+) 2 | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Own Home | | |
| 17. Father's Name (First, Middle, Last)
William T. MacIntyre | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary A. Alford | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mary E. Martin/Daughter | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2606 Turf Valley Road Ellicott City, Maryland 21042 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cemetery of the Holy Rood | | Date
6/2/99 | | 20c. Location - City or Town, State
Westbury, New York | | | |
| 21. Signature of Funeral Service Licensee
Guanta R Thomas | | | | | 22. Name and Address of Facility
Hubbard Funeral Home, Inc.
4107 Wilkens Avenue Baltimore, Maryland 21229 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. VANCOMYCIN RESISTANT ENTEROCOCCAL INFECTION OF URINARY TRACT.
Due to (or as a consequence of): TWO WEEKS
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
STATUS POST MENINGIOMA RESECTION
CHRONIC ATRIAL FIBRILLATION
SICK SINUS SYNDROME. | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | 29b. Signature and title of certifier
Kamal K. Dang | | | | | |
| 29c. License number
D18362 | | | | | 29d. Date signed (Month, Day, Year)
5-29-1999 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KOMAL K. DANG M.D., 3455 WILKENS AVE., BALTO., MD 21229. | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | | | 32. Registrar's Signature
B. Sparks | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.


17821

May 29, 1999 3:15 p.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

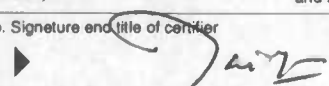
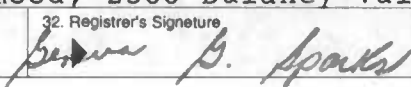
| | | | | | | | | | |
|---|--|---|--|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)
Frances A. Thalwitzer | | 2. Date of Death
Month May Day 29 Year 1999 | | 3. Time of Death
3:15 PM | | | | | |
| 4a. Facility Name (If not institution, give street and number)
Stella Maris Hospice | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore | | | | |
| 5. Social Security Number
219-30-2430 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
67 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb 18, 1932 | | 9. Birthplace (State or Foreign Country)
Balto, MD | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
3212 Overland Avenue | | | | 10f. Zip Code
21214 | | 10g. Citizen of What Country?
U.S.A. | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Home Maker | | | 16b. Kind of Business/Industry
Own Home | | |
| 17. Father's Name (First, Middle, Last)
Vincent Borngiorno | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Patrinia | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Julie Brewer (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3212 Overland Avenue Balto, MD 21214 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery | | Date
6/2/99 | | 20c. Location - City or Town, State
Parkville, MD | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Rd.. Balto, MD 21211 | | | | | |

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | |
|---|--|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Pancreatic Cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
D43725 | |
| 29d. Date signed (Month, Day, Year)
6/1/99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093 | |
| 31. Date filed (Month, Day, Year)
JUN 03 1999 | | 32. Registrar's Signature
 | |

State Registrar

MD CASE

Frances Thalwitzer

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

A143

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17822

| | | | | | | | | |
|---|---|--|---|--|--|--------------------------------|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Willis Dean Treaster</u> | | | | 2. Date of Death
Month <u>MAY</u> Day <u>31</u> Year <u>1999</u> | | 3. Time of Death
<u>3:31 P.M.</u> | |
| | 4a. Facility Name (If not institution, give street and number)
<u>Union Memorial Hospital</u> | | | | 4b. City, Town, or Location of Death
<u>Baltimore</u> | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
<u>Unknown</u> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>76</u> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<u>Dec. 7, 1922</u> | 9. Birthplace (State or Foreign Country)
<u>Pennsylvania</u> |
| | Usual Residence of Decedent | | | | 10c. City, Town or Location
<u>Baltimore</u> | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10a. State
<u>MARYLAND</u> | | 10b. County | | 10e. Street and Number
<u>3113 ST. PAUL STREET</u> | | 10f. Zip Code
<u>21218</u> | |
| | 10g. Citizen of What Country?
<u>U.S.A.</u> | | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc.
Specify: <u>WHITE</u> | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12YRS</u> College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>PRINTER</u> | | 16b. Kind of Business/Industry
<u>Letter Press</u> | |
| | 17. Father's Name (First, Middle, Last)
<u>John R. Treaster</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Mildred Miller</u> | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<u>LAROL O'DELL</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>156 LUTHER STREET ABERDEEN, MARYLAND 21001</u> | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>EVANS FUNERAL CHAPEL - BELAIR, P.A.</u> | | 20c. Location - City or Town, State
<u>FOREST HILL, MARYLAND</u> | | 20d. Date
<u>JUNE 1999</u> | |
| | 21. Signature of Funeral Service Licensee
<u>[Signature]</u> | | | | 22. Name and Address of Facility
<u>EVANS FUNERAL CHAPEL - BELAIR, P.A. 21000</u>
<u>3 NEWPORT DRIVE FOREST HILL, MARYLAND</u> | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Myocardial Infarction</u>
<u>Arterial Disease</u> | | | | | | | |
| | 23c. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
<u>[Signature]</u> | | | | 29c. License number
<u>047123</u> | | 29d. Date signed (Month, Day, Year)
<u>May 31, 1999</u> | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>DR. JOSEPH P. BISHOP, M.D. 201 EAST UNIV. PKWY. BALTO. MD.</u> | | | | | | | |
| | 31. Date filed (Month, Day, Year)
<u>JUN 3 1999</u> | | | | 32. Registrar's Signature
<u>[Signature]</u> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17823

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
PEARL ANGELENE TESTERMAN | | | | 2. Date of Death
Month May Day 30 Year 1999 | | 3. Time of Death
8:15AM | |
| 4a. Facility Name (If not institution, give street and number)
MARINER HEALTH - BELAIR | | | | 4b. City, Town, or Location of Death
BELAIR | | 4c. County of Death
HARFORD | |
| 5. Social Security Number
214-14-4923 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
93 | | 8. Date of Birth (Month, Day, Year)
JUNE 23, 1905 | |
| 9. Birthplace (State or Foreign Country)
VIRGINIA | | 10a. State
MARYLAND | | 10b. County
HARFORD | | 10c. City, Town or Location
FOREST HILL | |
| 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
2005 HIGHPOINT ROAD | | 10f. Zip Code
21050 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
8 YRS. | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CUSTODIAN | | 16b. Kind of Business/Industry
SCHOOL BOARD OF HARFORD COUNTY | | 17. Father's Name (First, Middle, Last)
JAMES A. RICHARDSON | |
| 18. Mother's Name (First, Middle, Maiden Surname)
DORA FARMER | | 19a. Informant's Name/Relationship (Type, Print)
VIRGINIA OWEN | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3735 DAVIS CORNER ROAD STREET MARYLAND 21047 | | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify): | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
FREEWILL G. B. T. CH. L. CH. | | 20c. Date
JUNE 3 1999 | | 20d. Location - City or Town, State
FOREST HILL MARYLAND | | 21. Signature of Funeral Service Licensee
EVANS FUNERAL HOME | |
| 22. Name and Address of Facility
PEARL ANGELENE TESTERMAN, P.A. 21050 | | 22b. Address
3 NEWPORT DRIVE FOREST HILL, MARYLAND | | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Pneumonia | | Approximate Interval Between Onset and Death
2 weeks | |
| 23b. Due to (or as a consequence of):
Right Hip Fracture | | 23c. Due to (or as a consequence of):
ASCVD with | | 23d. Due to (or as a consequence of):
Vascular Dementia | | Approximate Interval Between Onset and Death
4 weeks | |
| 23e. Due to (or as a consequence of):
year | | 23f. Due to (or as a consequence of):
year | | 23g. Due to (or as a consequence of):
year | | Approximate Interval Between Onset and Death
year | |

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Pneumonia | | | | Approximate Interval Between Onset and Death
2 weeks | | | |
| 23b. Due to (or as a consequence of):
Right Hip Fracture | | | | Approximate Interval Between Onset and Death
4 weeks | | | |
| 23c. Due to (or as a consequence of):
ASCVD with | | | | Approximate Interval Between Onset and Death
year | | | |
| 23d. Due to (or as a consequence of):
Vascular Dementia | | | | Approximate Interval Between Onset and Death
year | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Reptile ulcer Disease | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year)
MAY 30 1999 | | | |
| 28b. Time of Injury
M | | | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. Signature and title of certifier
Dr. [Signature] | | | | 29c. License number
D16389 | | | |
| 29d. Date signed (Month, Day, Year)
MAY 31, 1999 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PERFECTO, V. ALVARADO, M.D. 1716 HARFORD RD PALLSTON MD 21047 | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | | 32. Registrar's Signature
[Signature] | | | |

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

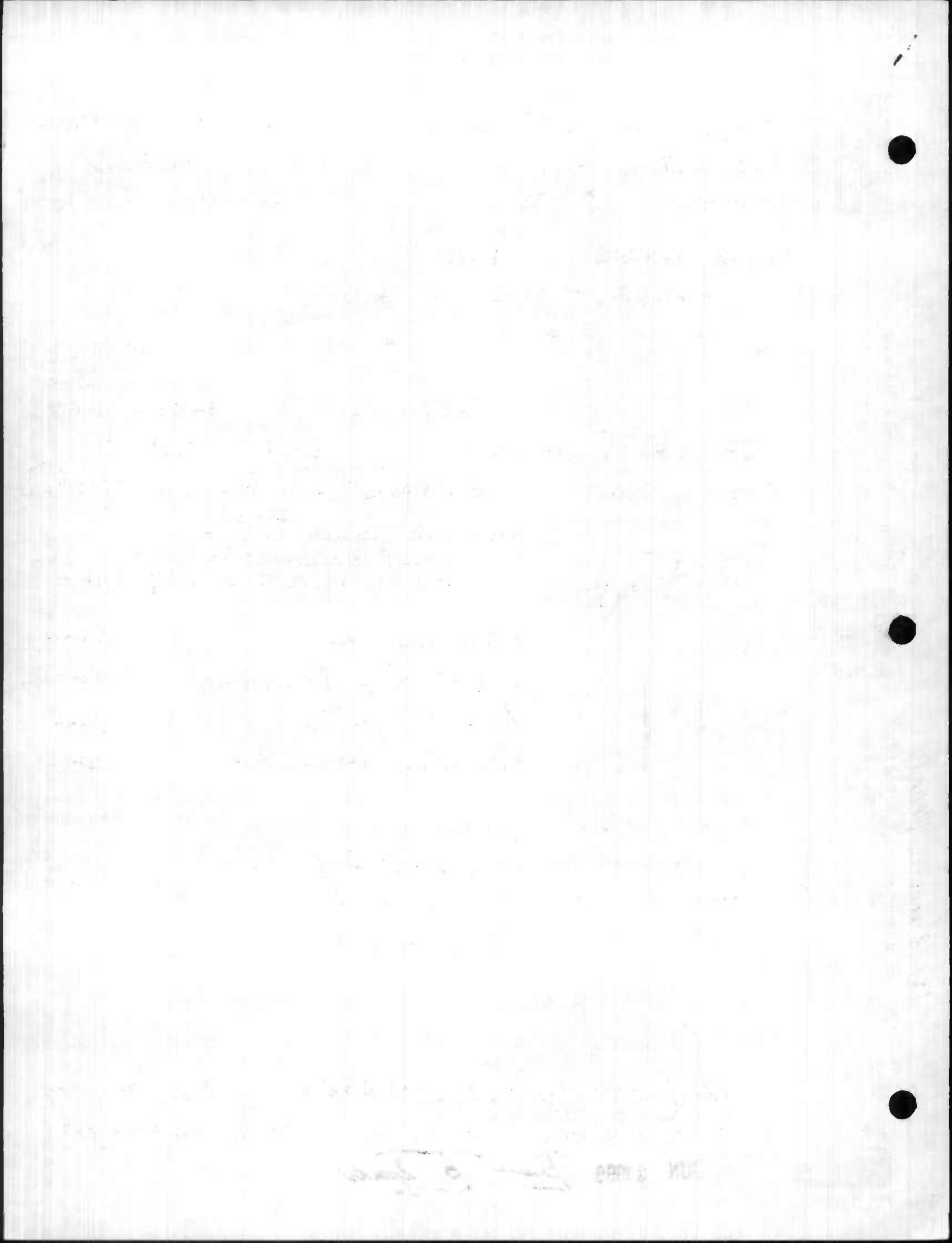
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Testerman, Pearl

A44



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Testudine

2. Date of Death
Month Day Year
May 29, 1999

3. Time of Death
11:55 AM

4a. Facility Name (If not institution, give street and number)

Manor Care Rossville

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

214-03-3986

6. Sex
1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

96

If Under 1 Year
Months Days

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year)

4/19/1903

9. Birthplace (State or Foreign
Country)

Sicily

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6629 Kenwood Avenue

10f. Zip Code

21237

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.
Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

4

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Baker

16b. Kind of Business/Industry

Bakery

17. Father's Name (First, Middle, Last)

Vincent Cammarata

18. Mother's Name (First, Middle, Maiden Surname)

Clementine Trionfo

19a. Informant's Name/Relationship (Type, Print)

Salvatore Testudine/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6629 Kenwood Avenue Baltimore, Maryland 21237

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Holy Redeemer Cemetery

Date

6/2/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Dippel Funeral Home Inc.

7110 Belair Road Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

Pneumonia

a. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute myelogenous Leukemia,
CHF, Severe Anemia.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical
examiner?

1 ☐ Yes 2 ☒ No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident

3 ☐ Suicide 4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier
(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. J. ... M.D.

29c. License number

D-38754

29d. Date signed (Month, Day, Year)

05-29-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAURA WASSERMAN, 404 EASTERN BLVD, MD-21221.

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

...

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5/29/99 11:55

Testudine, Mary

19749

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17825

| | | | | | | | | | | |
|--|---|---|--|--|--|--|--------------------------------|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MILDRED E. TUERK | | | | 2. Date of Death
Month Day Year
May 31st 1999 | | | | 3. Time of Death
9:50 PM | |
| | 4a. Facility Name (If not institution, give street and number)
North Arundel Hosp | | | | 4b. City, Town, or Location of Death
Glen Burnie | | | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
109-07-6016 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
91 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| | 8. Date of Birth (Month, Day, Year)
May 02 1908 | | 9. Birthplace (State or Foreign Country)
Maryland | | Usual Residence of Decedent | | 10a. State
Md. | | 10b. County
Anne Arundel Co. | |
| 10c. City, Town or Location
Glen Burnie | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
7900 Benesch Circle Apt. 776 | | 10f. Zip Code
21061 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | |
| 16. Kind of Business/Industry
Home Owner | | 17. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Home maker | | 18. Decedent's Name (First, Middle, Maiden Surname)
Minnie Gerstle | | 19. Father's Name (First, Middle, Last)
William Menger | | 20. Mother's Name (First, Middle, Maiden Surname)
Minnie Gerstle | | |
| 21. Informant's Name/Relationship (Type, Print)
David Hall (Friend) | | 22. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2708 Robin Road Glen Burnie, Md. 21060 | | 23a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 23b. Place of Disposition (Name of cemetery, crematory or other place)
Moreland Memorial Park | | 23c. Date
6/4/99 | | |
| 23d. Location - City or Town, State
Baltimore, Md. | | 24. Signature of Funeral Service Licensee
Harold A. Hayes | | 25. Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
3204 Mountain Road, Pasadena, Md. 21122 | | 26. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. Congestive Heart Failure
Due to (or as a consequence of):
Coronary Artery Disease
Due to (or as a consequence of):
Due to (or as a consequence of):
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
more than 1 yr | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 27. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 28. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 29. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. Place of Death (Check only one)
Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | |
| 29b. Signature and title of certifier
Dr. Smith, MD | | 29c. License number
D48006 | | 29d. Date signed (Month, Day, Year)
May 31st 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KOFI BORTSEY, 301 Hosp. Dr, Glen Burnie MD 21061 | | 31. Date filed (Month, Day, Year)
JUN 3 1999 | | |
| 32. Registrar's Signature
Benjamin B. Sparks | | State Registrar | | Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. | | To Be Completed by Funeral Director | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17826

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Sarah Helen Tucker

2. Date of Death

Month
June

Day
2

Year
1999

3. Time of Death

0800

4a. Facility Name (If not institution, give street and number)

Augsburg Lutheran Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

214-18-0876

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 15, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Owings Mills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

213 Uppergate Court

10f. Zip Code

21117

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Harry Dorsey

18. Mother's Name (First, Middle, Maiden Surname)

Charlotte Anderson

19a. Informant's Name/Relationship (Type, Print)

Joan Walsch (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

213 Uppergate Court Owings Mills, Maryland 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

6/4/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Christina S. Nelson

22. Name and Address of Facility

McCully-Polyniak Funeral Home P.A.

237 E. Patapsco Avenue Baltimore, Maryland 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ASCVD

Approximate Interval Between Onset and Death

7 years

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation

2 ☐ Accident 6 ☐ Could not be determined

3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

037573

29d. Date signed (Month, Day, Year)

June 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeff Z. Ball MD 7220 Park Heights Ave Baltimore MD 21208

31. Date filed (Month, Day, Year)

JUN 3 1999

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AH 4

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

WRC
99-3090-510
DAVID
TYSZKICUKZ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

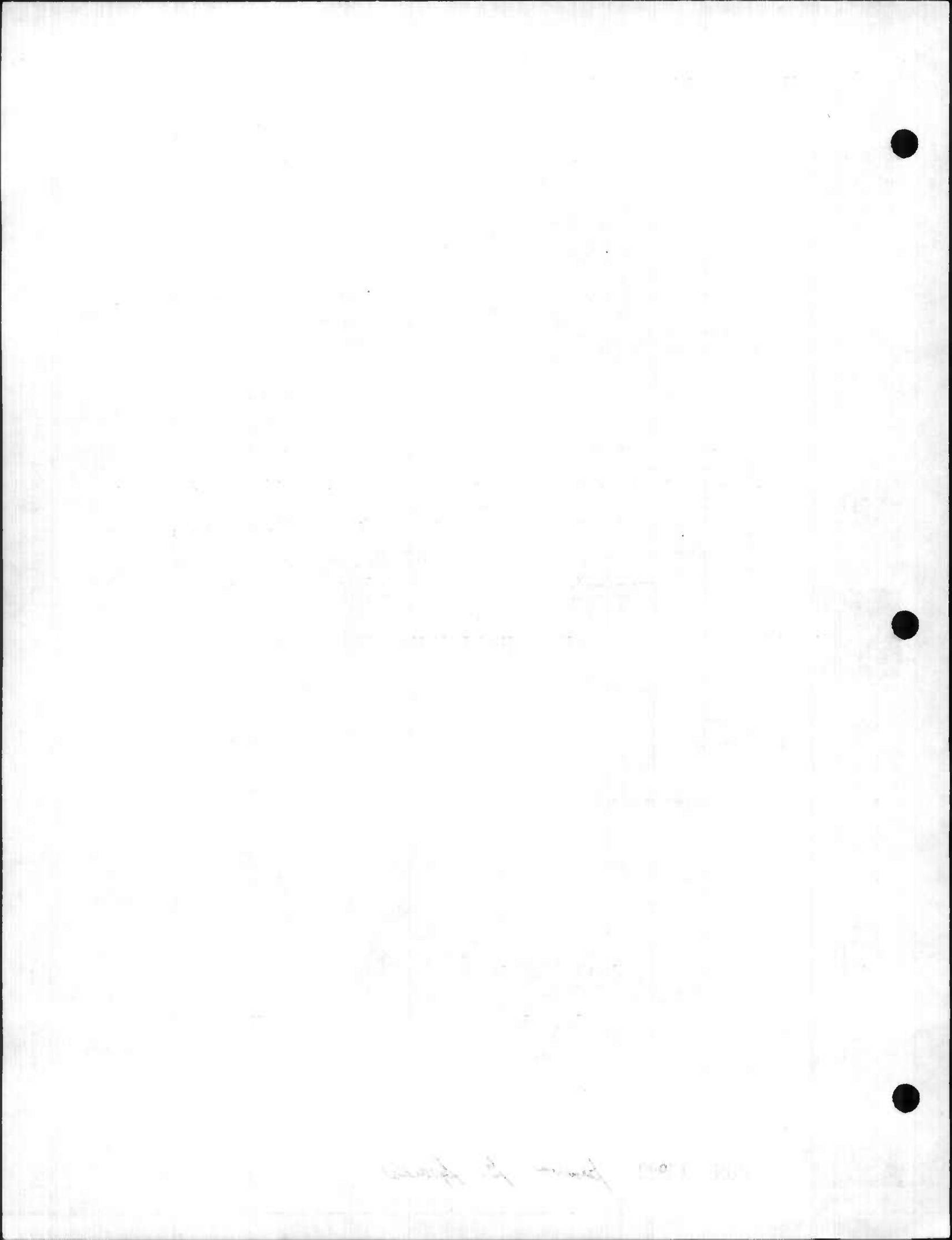
ITEMS: #23 PART 1, 27, 28A-F PER MEO G772

Certificate of Death

Reg. No.

99 17827

| | | | | | | | | |
|---|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
David M. Tyszkiewicz | | | | 2. Date of Death
Month Day Year
MAY 29, 1999 | | 3. Time of Death
2:40 PM. | |
| | 4a. Facility Name (If not institution, give street and number)
4234 AUDREY AVE. | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
Baltimore City | |
| Funeral
Director | 5. Social Security Number
216-90-4260 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
36 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb. 26, 1963 | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country)
Maryland | | 10. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Glen Burnie | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
209 Water Fountain Court | | 10f. Zip Code
21060 | | 10g. Citizen of What Country?
United States | | | |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Painter | | 16b. Kind of Business/Industry
Construction | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
David A. Tyszkiewicz | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Norma L. Kahmer | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
David A. Tyszkiewicz/Father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
209 Water Fountain Ct. Glen Burnie, MD 21060 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Mem. Pk. | | 20c. Location - City or Town, State
Elkridge, MD | | | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home P.A.
421 Crain Hwy. S.E. Glen Burnie, MD 21061 | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. ACUTE NARCOTIC INTOXICATION
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
Found: 5-29-99 | | 28b. Time of Injury
Found: 2:30 P M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
FOUND AT HOME | | 28d. Describe how injury occurred
UNKNOWN | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4234 AUDREY AVE. BALTIMORE, MARYLAND | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | 29b. Signature and title of certifier
Dennis J. Chute MD | |
| | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 30, 1999 | | | | | |
| State
Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
JUN 3 1999 | | 32. Registrar's Signature
Dennis J. Chute MD | | | | | |



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17828

| | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Cecelia Audra Urtes | | | | | 2. Date of Death
Month Day Year
May 31, 1999 | | 3. Time of Death
6:30 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
Cozy Country Corner Assisted Living | | | | | 4b. City, Town, or Location of Death
Chase | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
212-10-2722 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
86 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb. 19, 1913 | | 9. Birthplace (State or Foreign Country)
West Virginia | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Edgemere | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
3206 River Drive Road | | | | 10f. Zip Code
21219 | | 10g. Citizen of What Country?
United States | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Years
College (14 or 5+) College (14 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Seamstress | | | 16b. Kind of Business/Industry
Sewing Industry | | | |
| | 17. Father's Name (First, Middle, Last)
Samuel Collins | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Eva Buntun | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Glen Urtes / Son | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3206 River Drive Road Edgemere, MD 21219 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hill Mem. Gdns. | | | 20c. Date
6/3/1999 | | 20d. Location - City or Town, State
Middle River, MD | | |
| | 21. Signature of Funeral Service Licensee
<i>Stephanie Haskel</i> | | | | | 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <i>Cardiac arrhythmia</i>
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Coronary artery Disease</i>
<i>orthostatic hypotensive</i>
<i>non insulin dependent DM</i> | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>assisted living</i> | | | | | | | |
| | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| State Registrar | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of certifier
<i>Ronald Attarasio, MD</i> | | | | | 29c. License number
D-28097 | | 29d. Date signed (Month, Day, Year)
6-1-99 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
1012 OLD NORTH POINT Rd. Balt. Md. 21224 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 3 1999 | | 32. Registrar's Signature
<i>Laura B. Sparks</i> | | | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17829

Amended Item#20b perFH G772 6/3/99 EW

| | | | | | | | | | |
|--|---|---|--|---|--|--|-------------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Elizabeth Cameron Wyrick | | | | 2. Date of Death
Month Day Year
May 25, 1999 | | 3. Time of Death
11:50 p.m. | | |
| | 4a. Facility Name (If not institution, give street and number)
Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | | |
| Funeral
Director | 5. Social Security Number
227-07-3496 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
84 Yrs. | 8. Date of Birth (Month, Day, Year)
Sept. 7, 1914 | 9. Birthplace (State or Foreign Country)
Virginia | | | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Deale | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number
626 E. Marshall Avenue | | | | 10f. Zip Code
20751 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Sales Clerk | | 16b. Kind of Business/Industry
Retail | | | |
| 17. Father's Name (First, Middle, Last)
William Cameron McGlothlin | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Minnie Ann Sutherland | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Johnnie Sellers/Granddaughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8111 Pinehill Street, Laurel, Maryland 20707 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Highland Memorial Park | | 20c. Location - City or Town, State
Danville, Virginia | | 20d. Date
5/29/99 | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Fleck Funeral Home, Inc.
7601 Sandy Spring Road, Laurel, Maryland 20707 | | | | | |
| 23a. Print, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
2 DAYS | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
N/A | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
DSMITCHELL | | | | 29c. License number
MD D39037 | | 29d. Date signed (Month, Day, Year)
5/26/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DOUGLAS S MITCHELL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS MD 21401 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | | 32. Registrar's Signature
 | | | | | |

State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-17630

| | | | | | | | | | | |
|---|---|--|--|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Christopher W. Watson | | | | 2. Date of Death
Month Day Year
MAY 26, 1999 | | | | 3. Time of Death
8:50 AM | |
| | 4a. Facility Name (If not institution, give street and number)
1935 Victory Drive | | | | 4b. City, Town, or Location of Death
Halethorpe | | | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
212-98-1955 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
31 Yrs. | | 8. Date of Birth (Month, Day, Year)
JULY 10, 1967 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Halethorpe | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
1935 Victory Drive | | | | 10f. Zip Code
21227 | |
| | 10g. Citizen of What Country?
USA | | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Labor | | | | 16b. Kind of Business/Industry
Tree Trimming | | | | 17. Father's Name (First, Middle, Last)
James A. Watson, III | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Brenda Rebstock | | | | 19a. Informant's Name/Relationship (Type, Print)
Brenda Watson - mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1935 Victory Drive, Halethorpe, Maryland 21227 | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Memorial Pk. | | | | 20c. Location - City or Town, State
Elkridge, Md. | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc.
7250 Washington Blvd., Elkridge, Md. 21075 | | | | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
a. Testicular Cancer
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, lecture, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
051260 | | | | 29d. Date signed (Month, Day, Year)
05 31 99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Barry Meisenberg, MD, University Cancer Center, 22 S. Greene St., Balto., Md. | | | | 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | | 32. Registrar's Signature
 | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17831

| | | | | | | | | | | |
|--|--|-----------------------|---|--|---|-----------------|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Melba R. Waters | | | | 2. Date of Death
Month Day Year
May 31, 1999 | | | | 3. Time of Death
11:47 AM | |
| | 4a. Facility Name (If not Institution, give street and number)
5753 Elkridge Heights Road | | | | 4b. City, Town, or Location of Death
Elkridge | | | | 4c. County of Death
Howard | |
| Funeral
Director | 5. Social Security Number
218-12-0292 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
91 Yrs. | | 8. Date of Birth (Month, Day, Year)
JUNE 2, 1907 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
Howard | | 10c. City, Town or Location
Elkridge | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10a. Street and Number
5753 Elkridge Heights Road | | | | 10f. Zip Code
21075 | | | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | | 16b. Kind of Business/Industry
Own Home | | |
| 17. Father's Name (First, Middle, Last)
Edward W. Robinson | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Winnie Holland | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Faith W. Howell - daughter | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5753 Elkridge Heights Rd., Elkridge, Md. 21075 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Peters Cemetery | | | Date
6/03/99 | | 20c. Location - City or Town, State
Odenton, Maryland | | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc.
7250 Washington Blvd., Elkridge, Md. 21075 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. FAILURE TO THRIVE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SENILE DEMENTIA
DEBILITY
MALNUTRITION | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | 29c. License number
D22832 | | 29d. Date signed (Month, Day, Year)
6/2/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Soon Ja Kim, MD 5808 Main Street Elkridge, Md 21075 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020
perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17832

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Viola M. Walsh

2. Date of Death

June 1, 1999

3. Time of Death

6:30 AM

4a. Facility Name (If not institution, give street and number)

12590 Hidden Woods Road

4b. City, Town, or Location of Death

Greensboro

4c. County of Death

Caroline County

Funeral
Director

5. Social Security Number

215-36-7911

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 13, 1907

9. Birthplace (State or Foreign Country)

Baltimore, MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3516 Clipper Road

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Bleck, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

In Own Residence

17. Father's Name (First, Middle, Last)

Edward Phillips

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Cox

19a. Informant's Name/Relationship (Type, Print)

Viola Fawcett Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7609 Wilhelm Avenue Baltimore, Maryland 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Druid Ridge Cemetery

Date

6/4/99

20c. Location - City or Town, State

Pikesville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, Maryland 21211

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Acute Myocardial Infarction

One

Due to (or as a consequence of):

b.

CORONARY ARTERY DISEASE

years

Due to (or as a consequence of):

c.

Hypertension

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OSTEOARTHRITIS

Panic disorder

Mild senile dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

daughter's home

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0015462

29d. Date signed (Month, Day, Year)

June 3 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIGUEL KARACUSCHANSKY M.D. 300 E. 33rd ST. BALTO MD. 21218

31. Date filed (Month, Day, Year)

JUN 03 1999

32. Registrar's Signature

Benjamin B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17833

Physician
/Medical
Examiner

Funeral
Director

| | | | | | |
|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
Vernon Webb | | 2. Date of Death
Month 6 Day 1 Year 99 | | 3. Time of Death
435p | |
| 4a. Facility Name (If not institution, give street and number)
Sandtown Winchester | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| 5. Social Security Number
212-14-9252 | | 6. Sex
1 M 2 F | | 7. Age (In yrs. last birthday)
94 Yrs. | |
| 8. Date of Birth (Month, Day, Year)
Sept. 2, 1904 | | 9. Birthplace (State or Foreign Country)
North Carolina | | | |
| 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| 10d. Inside City Limits
1 Yes 2 No | | 10e. Street and Number
1828 E. Chase St. | | 10f. Zip Code
21213 | |
| 10g. Citizen of What Country?
USA | | 11. Marital Status
3 Widowed 2 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc.
African American | | 15. Decedent's Education (Specify only highest grade completed)
8 Elementary/Secondary (0-12) 0 College (1-4 or 5+) | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Tailor | | 16b. Kind of Business/Industry
Private Business | | 17. Father's Name (First, Middle, Last)
George Webb | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Flora Webb | | 19a. Informant's Name/Relationship (Type, Print) (niece)
Mrs. Lauretta Johnson | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6 S. Culver St. Balto. Md. 21229 | |
| 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus Mem. Park | | 20c. Location - City or Town, State
Balto. Md. | |
| 21. Signature of Funeral Service Licensee
Joseph L. Russ | | 22. Name and Address of Facility
Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
CONGESTIVE HEART FAILURE
HASCVS | |
| 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | | 24a. Was an autopsy performed?
1 Yes 2 No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | |
| 25. Was case referred to medical examiner?
1 Yes 2 No | | 26. Place of Death (Check only one)
4 Nursing Home 5 Residence 6 Other (Specify) | | 27. Manner of Death
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | |
| 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | |
| 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. Signature and title of certifier
Richard F. Tyson | | 29c. License number
510268 | | 29d. Date signed (Month, Day, Year)
06-02-99 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Richard F. Tyson M.D. 936 West North Ave. Balt. Md. 21217 | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 03 1999 | | 32. Registrar's Signature
B. Sparks | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

once.

VOID

CERTIFICATE #

17834

SEE

CERTIFICATE #

16071

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17835

| | | | | | | | | | |
|---|--|---|--|--|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
FRANK WRIGHT SR | | | | 2. Date of Death
Month Day Year
MAY 30th 1999 | | 3. Time of Death
8:46 am | | |
| | 4a. Facility Name (If not institution, give street and number)
JOHNS HOPKINS BAYVIEW | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
MARYLAND | | |
| Funeral
Director | 5. Social Security Number
212-32-7293 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
61 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 19, 1937 | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
215 N. Curley Street | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
U. S. A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th Grade | | College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Pipe Fitter | | 16b. Kind of Business/Industry
Steel Company | | | |
| 17. Father's Name (First, Middle, Last)
Claude F. Wright | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Anna Cortis | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Vicki Stone (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4311 Blakely Avenue, Baltimore, Maryland 21236 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Most Holy Redeemer | | 20c. Location - City or Town, State
Baltimore, Maryland | | 20d. Date
5/3/99 | | | |
| 21. Signature of Funeral Service Licensee
Brian D. Jones | | | | 22. Name and Address of Facility
Schimunek Funeral Home Inc.
3331 Brehms Lane, Baltimore, Maryland 21213 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
SEPSIS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
RENAL FAILURE
PULMONARY EMBOLI
INFILTRATIVE HEPATIC DISEASE | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | Approximate Interval Between Onset and Death
3 DAYS | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
RENAL FAILURE
PULMONARY EMBOLI
INFILTRATIVE HEPATIC DISEASE | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. Place of Death (Check only one)
Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | |
| 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Dr. N. Chauhan MD | | 29c. License number
P12554 | | 29d. Date signed (Month, Day, Year)
May 30th 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR NARESH CHAUHAN, JOHNS HOPKINS BAYVIEW MEDICAL CENTRE | | | | 31. Date filed (Month, Day, Year)
JUN 3 1999 | | | | 32. Registrar's Signature
[Signature] | |

Baltimore, Maryland 21215-0020

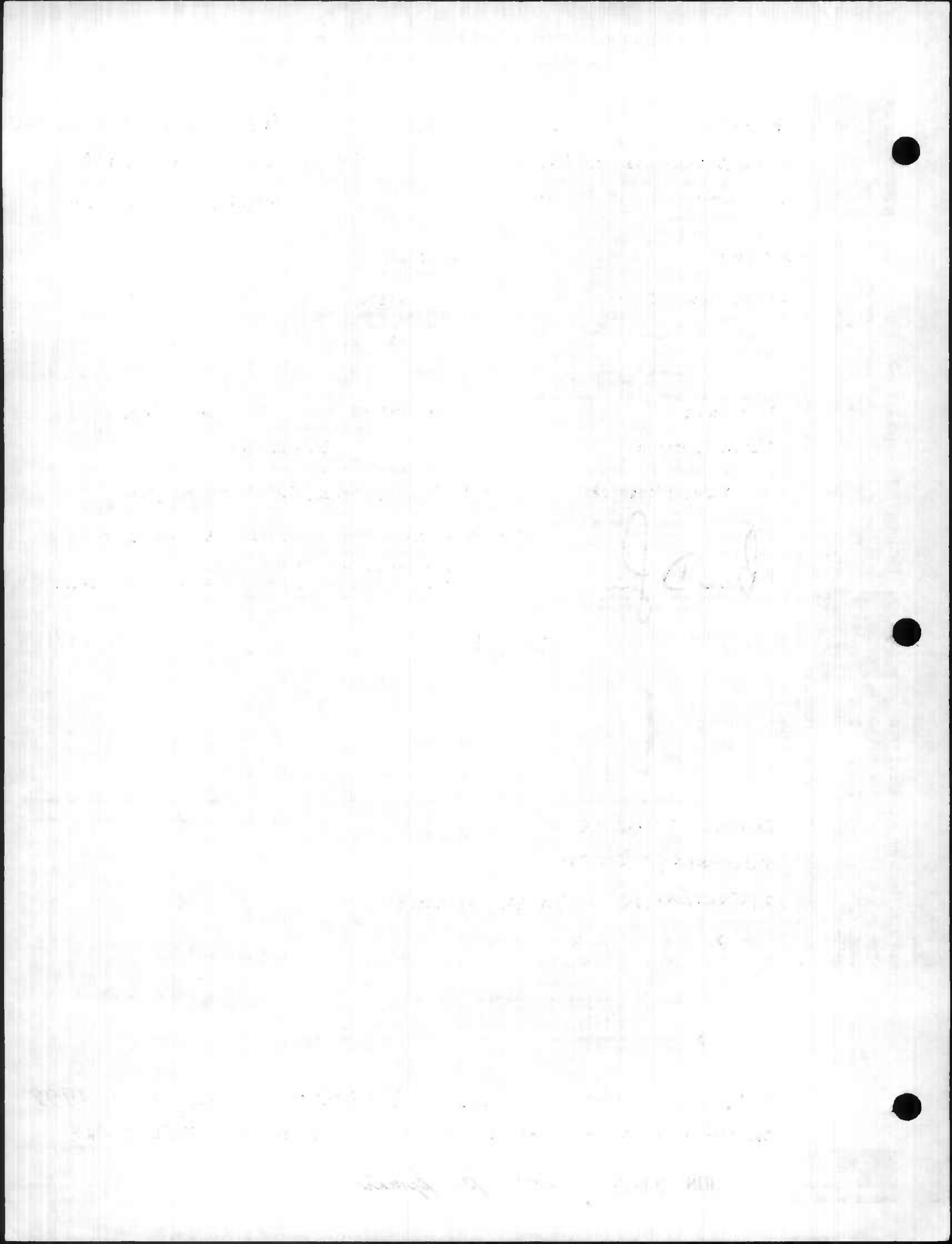
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



WRC
99-2954-005
SCARLET
WOCKENFUSS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, II, 27 PER MEO G772

Certificate of Death

Reg. No.

99 17837

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
Scarlet Jan Wockenfuss | | 2. Date of Death
Month Day Year
MAY 20, 1999 | | 3. Time of Death
10:05 PM. | |
| 4a. Facility Name (If not institution, give street and number)
FRANKLIN SQUARE HOSPITAL | | 4b. City, Town, or Location of Death
ESSEX | | 4c. County of Death
BALTIMORE | |
| 5. Social Security Number
216-86-5949 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
38 Yrs. | |
| 8. Date of Birth (Month, Day, Year)
4 22 1961 | | 9. Birthplace (State or Foreign Country)
Maryland | | | |
| 10a. State
Md. | | 10b. County
Baltimore Co. | | 10c. City, Town or Location
Essex | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
4 Landmark Court | | 10f. Zip Code
21221 | |
| 10g. Citizen of What Country?
U.S.A. | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Nursing | | 16b. Kind of Business/Industry
Private | |
| 17. Father's Name (First, Middle, Last)
William A. West | | 18. Mother's Name (First, Middle, Maiden Summa)
Ruby Taylor | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Ruby Taylor West/Mother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4 Landmark Ct. Essex, Maryland 21221 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Park | | 20c. Location - City or Town, State
5/28/99 Woodlawn, Md. | |
| 21. Signature of Funeral Service Licensed
 | | 22. Name and Address of Facility
William C. Brown Community Funeral Home
1206 W. North Avenue, Baltimore, Md. 21217 | | Approximate Interval Between Onset and Death | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
BRONCHIAL ASTHMA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
M | | 28b. Time of Injury
1 Yes <input type="checkbox"/> No | |
| 28c. Describe how injury occurred | | 28d. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | |
| 29d. Date signed (Month, Day, Year)
MAY 22, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | | |
| 31. Date filed (Month, Day, Year)
JUN 3 1999 | | 32. Registrar's Signature
 | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#18 perFH G774 8/25/99 EW

Certificate of Death

Reg. No.

99 17838

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marilyn Ann Zentz

2. Date of Death

Month

Day

Year

JUNE

01

1999

3. Time of Death

1840 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

807 LAKESHORE DRIVE

4b. City, Town, or Location of Death

MITCHELLVILLE

4c. County of Death

PRINCE GEORGES

5. Social Security Number

377 40 3584

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

57

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Dec. 28, 1941

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Mitchellville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

807 Lakeshore Drive

10f. Zip Code

20721

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Office Manager

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Philip Zente

18. Mother's Name (First, Middle, Maiden Surname)

Olga Nygaard Nygaard

19a. Informant's Name/Relationship (Type, Print)

Teresa M. Ayanian Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

315 Woodside Place Waldorf Maryland 20601

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Crematory

Date

June 3, 1999

20c. Location - City or Town, State

Alexandria Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.

16000 Annapolis Rd. Bowie Maryland 20715

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

chock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Pending investigation☐ Accident☐ Suicide☐ Homicide☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARIO F. GOHE JR MD 309 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

31. Date filed (Month, Day, Year)

JUN

3 1999

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS. #5 PER F.H G772 6-14-99 WR.

Certificate of Death

Reg. No. 99-17839

| | | | | | | | | |
|--|--|---|--|--|---|--|------------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DONALD ARTHUR | | | | 2. Date of Death
Month MAY Day 17 Year 99 | | 3. Time of Death
1:05 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Union Memorial Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
231-36-1728 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
67 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
11/04/1931 | | 9. Birthplace (State or Foreign Country)
Washington DC |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
Prince Georges | | 10c. City, Town or Location
Bowie | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
12508 Hemm Place | | | | 10f. Zip Code
20716 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: Available | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Budget Analyst | | 16b. Kind of Business/Industry
State University | | |
| 17. Father's Name (First, Middle, Last)
Lester Maxwell Arthur | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Gladys Louise Richardson | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Maria Arthur Parker (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13005 Viewpoint Lane, Bowie MD 20715 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | Date
5/18/99 | | 20c. Location - City or Town, State
Alexandria VA | | |
| 21. Signature of Funeral Service Licensee
Melanie Wilhelm Hagner | | | | 22. Name and Address of Facility
Advent Funeral & Cremation Services
Annapolis MD 21401 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. SEPTIC SHOCK
Due to (or as a consequence of):</p> <p>b. DECUBITUS ULCER'S
Due to (or as a consequence of):</p> <p>c. DIABETES
Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p>FOUR DAYS</p> <p>MONTH'S</p> <p>TWENTY YEARS</p> </div> </div> | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Sonal MD | | | | 29c. License number
AT2438946 | | 29d. Date signed (Month, Day, Year)
05/17/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SONAL SETHI, UNION MEMORIAL HOSPITAL, 201 EAST UNIVERSITY PARKWAY BALTIMORE, MD - 21239 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 19 1999 | | 32. Registrar's Signature
[Signature] | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17840

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MILTON ARTIS

2. Date of Death
Month Day Year
May 16, 19993. Time of Death
6:47 A.M.

4a. Facility Name (If not institution, give street and number)

11216 Lake Overlook Place

4b. City, Town, or Location of Death

Mitchellville

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

231-08-5888

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

37 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

October 22, 1961

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Mitchellville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11216 Lake Overlook Place

10f. Zip Code

20721

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Customer Specialist Engineer

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Lee Anderson Artis

18. Mother's Name (First, Middle, Maiden Surname)

Mamie Woodley

19a. Informant's Name/Relationship (Type, Print)

Zoe M. Artis/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11216 Lake Overlook Place, Mitchellville, Maryland 20721

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Tabor Cemetery

Date

05/23
1999

20c. Location - City or Town, State

Newsoms, Virginia

21. Signature of Funeral Service Licensee

Nancy A. Perantoni

22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Blunt Force and Sharp Force Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

Found 05-16-1999

28b. Time of Injury

Found 6:45 A

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28d. Describe how injury occurred

Subject was stabbed & Beaten

28f. Location (Street and Number or Rural Route Number, City or Town, State) 11216 Lake Overlook Pl., Mitchellville, MD

29e. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dennis J. Chute MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis Chute M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

3. Time of Death
4:30 A.M.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Goldie Glendora Triplett Brant

2. Date of Death
Month Day Year
MAY 21 99

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

232-26-1583

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Nov. 14, 1904

9. Birthplace (State or Foreign Country)

WVA

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11122 Valley Rd. N.E.

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5

Collega (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Textile

17. Father's Name (First, Middle, Last)

John J. Triplett

18. Mother's Name (First, Middle, Maiden Surname)

Nan Faulk

19a. Informant's Name/Relationship (Type, Print)

Richard D. VanFleet (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12414 Melody Lane N.E. Cumberland, Md. 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sunset Memorial Park

Date

5/24/99

20c. Location - City or Town, State

Cumberland, MD.

21. Signature of Funeral Service Licensee

Robert C. Adams

22. Name and Address of Facility

Merritt-Adams Funeral Home, P.A.
404 Decatur St. Cumberland, Md. 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Carcinoma of Breast Advanced

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

April 1999

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient

2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Qamar Zaman M.D. MD

29c. License number

D 23371

29d. Date signed (Month, Day, Year)

May 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

QAMAR ZAMAN M.D., 625 KENT AVENUE, SUITE 102 CUMBERLAND MD 21502

31. Date filed (Month, Day, Year)

MAY 25 1999

32. Registrar's Signature

B. Spaul

State
Registrar

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

GOLDIE BRANT 232261583

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17842

| | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Robbie Nell Bell | | | | 2. Date of Death
Month Day Year
May 13, 1999 | | | | 3. Time of Death
1:30PM | | |
| | 4a. Facility Name (If not institution, give street and number)
Chesapeake Future Care | | | | 4b. City, Town, or Location of Death
Annapolis | | | | 4c. County of Death
Anne Arundel | | |
| Funeral
Director | 5. Social Security Number
257-10-3152 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
82 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 4, 1917 | | 9. Birthplace (State or Foreign Country)
Georgia | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Annapolis | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
217 Victor Parkway Apt. G. | | | | 10f. Zip Code
21403 | | 10g. Citizen of What Country?
United States | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | | 16b. Kind of Business/Industry
Own home | | | |
| 17. Father's Name (First, Middle, Last)
James L. Anderson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Dessie Fortner | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Patrick J. Bell (son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5 Wainwright Ave. Annapolis, MD 21403 | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
The Catholic Cemetery | | 20c. Date
5/18/99 | | 20d. Location - City or Town, State
Savannah, Georgia | | | | | |
| 21. Signature of Funeral Service Licensee
<i>Beverly M. Barber</i> | | | | 22. Name and Address of Facility
John M. Taylor Funeral Home, Inc.
147 Duke of Gloucester St. Annapolis, MD 21401 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <i>Pneumonia</i>
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death
<i>5 Days</i> | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Coronary Artery Disease</i> | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>William M. ... Attending Doctor</i> | | | | 29c. License number
<i>D 21684</i> | | 29d. Date signed (Month, Day, Year)
<i>5.14.1999</i> | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>C.V. CYRIAC-M-D 8109 RITCHIE HWY, PASADENA, MD 21123</i> | | | | | | | | | | | |
| State Registrar | | 31. Date filed (Month, Day, Year)
MAY 17 1999 | | 32. Registrar's Signature
<i>Beverly M. Barber</i> | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 17843
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Samantha Dawn Marie Battaglia 2. Date of Death Month 05 Day 16 Year 99 3. Time of Death 2:10am

Funeral
Director

4a. Facility Name (If not institution, give street and number) Mount Washington Pediatric Hospital 4b. City, Town, or Location of Death Baltimore 4c. County of Death Baltimore City

5. Social Security Number 220-06-4536 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) 14 Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) JAN. 25, 1985 9. Birthplace (State or Foreign Country) MARYLAND

Usual Residence of Decedent 10a. State MARYLAND 10b. County ANNE ARUNDEL 10c. City, Town or Location BROOKLYN PARK 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number 5220 PATRICK HENRY DRIVE 10f. Zip Code 21225 10g. Citizen of What Country? U.S.A.

11. Marital Status ☒ Never Married ☐ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (14 or 5+) MINOR 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MINOR 16b. Kind of Business/Industry MINOR

17. Father's Name (First, Middle, Last) MARSHALL BATTAGLIA 18. Mother's Name (First, Middle, Maiden Surname) ANGELA FONTZ HEBERLE

19a. Informant's Name/Relationship (Type, Print) ANGELA HEBERLE (MOTHER) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5220 PATRICK HENRY DRIVE, BROOKLYN PARK, MD 21225

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK Date 5-19-1999 20c. Location - City or Town, State GLEN BURNIE, MD

21. Signature of Funeral Service Provider [Signature] 22. Name and Address of Facility SINGLETON FUNERAL HOME, PA.
1 SECOND AVE., S.W., GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory failure Due to (or as a consequence of): Reactive airway disease Approximately Interval Between Onset and Death 14 hours
 b. Reactive airway disease Due to (or as a consequence of): Reactive airway disease 14 hours
 c. Due to (or as a consequence of):
 d. Due to (or as a consequence of):
 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last {

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Osteogenesis imperfecta 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☐ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? ☐ Yes ☐ No 28d. Describe how Injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Sandra Rely M.D. 29c. License number D0054161 29d. Date signed (Month, Day, Year) 05-16-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1708 West Rogers Avenue Baltimore, MD 21209

State
Registrar

31. Date filed (Month, Day, Year) MAY 17 1999 32. Registrar's Signature [Signature]

Baltimore, Maryland 21215-0020

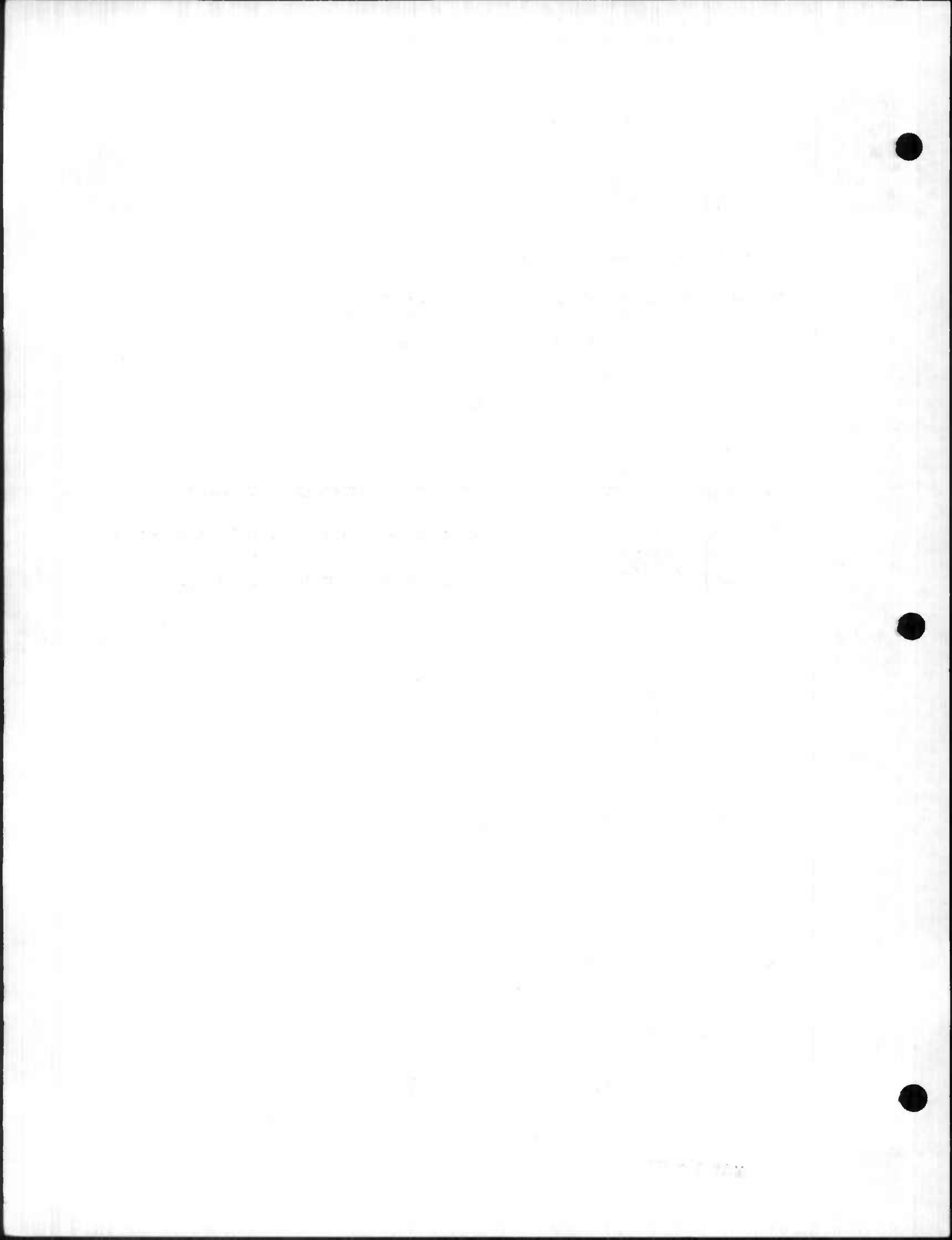
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

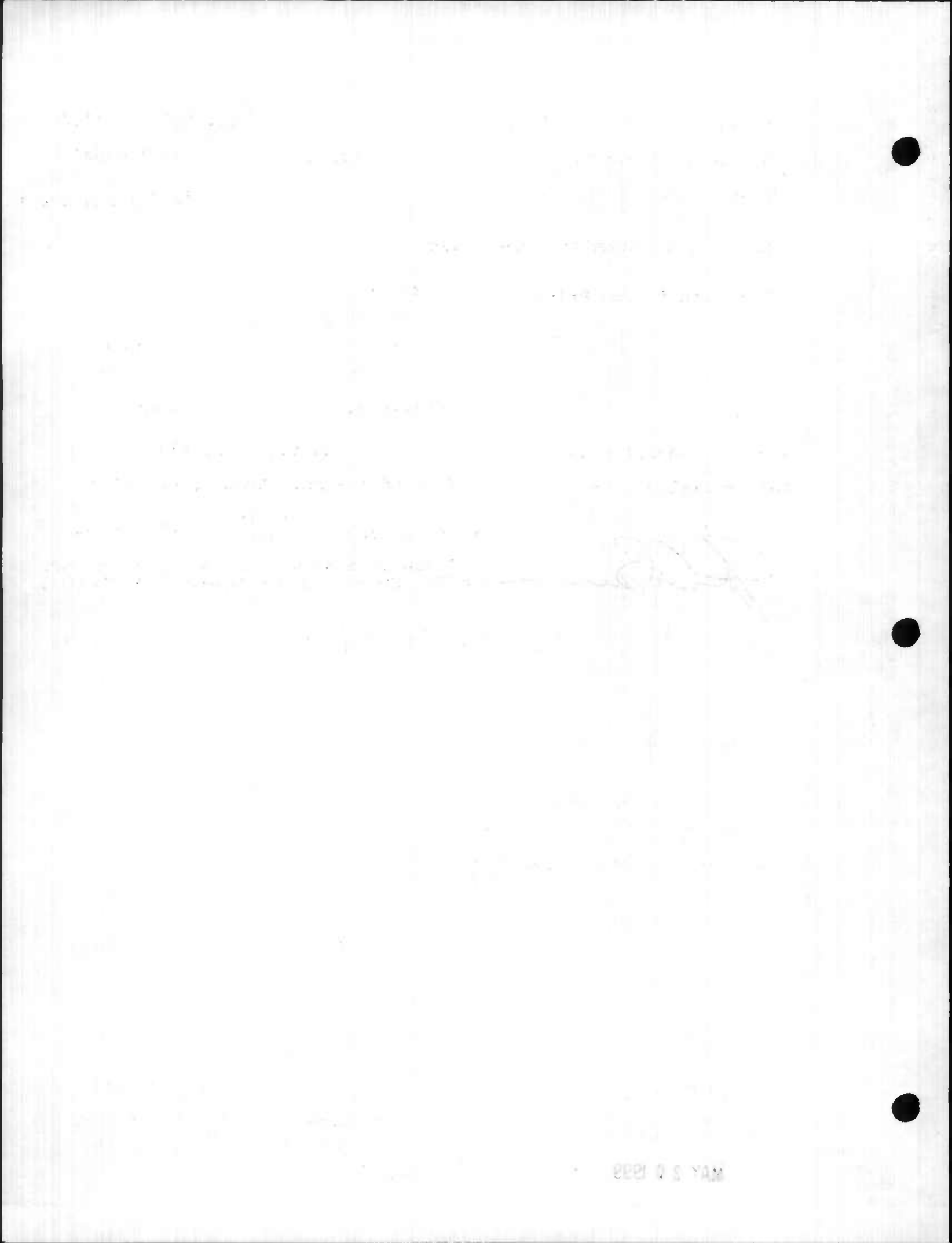
Certificate of Death

Reg. No.

99 17844

| | | | | | | | | | | | | | | | |
|--|--|--|---|---|--|---|---|--|--|---------------------------------|--|--|--|-----------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Mildred Isabel Bialousz | | | | 2. Date of Death
Month Day Year
May 18, 1999 | | | | 3. Time of Death
11:45 am | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Futurecare Chesapeake | | | | 4b. City, Town, or Location of Death
Arnold | | | | 4c. County of Death
Anne Arundel | | | | | | |
| Funeral
Director | 5. Social Security Number
062-03-8469 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
90 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec 19, 1908 | | 9. Birthplace (State or Foreign Country)
Pennsylvania | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Annapolis | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | |
| | 10e. Street and Number
872 Chestnut Tree Drive | | | | 10f. Zip Code
21401 | | 10g. Citizen of What Country?
USA | | | | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Home | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Joseph Danielowicz | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Aniela Kowalski | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Walter Bialousz/son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1479 Grandview Rd., Arnold, MD 21012 | | | | | | | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory | | Data
May 19 1999 | | 20c. Location - City or Town, State
Baltimore, MD | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park F.H. 495 Gov. Ritchie Highway, Severna Park, MD 21146 | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.

Coronary artery disease
Ischemic cardiomyopathy | | | | | | | | Approximate Interval Between Onset and Death
months | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Coronary artery disease
Ischemic cardiomyopathy | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. Place of Death (Check only one)
4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D-40521 | | 29d. Date signed (Month, Day, Year)
May 18, 1999 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
DR OCHANE
7845 Oakwood Road Suite 205 Glen Burnie, MD 21061 | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 20 1999 | | 32. Registrar's Signature
 | | | | | | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17845

| | | | | | | | | |
|--|--|------------------------------------|--|--|---|---|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Robert B. Bartlett | | | | 2. Date of Death
Month Day Year
May 16, 1999 | | 3. Time of Death
9:01 am | |
| | 4a. Facility Name (If not institution, give street and number)
Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
212-22-6447 | | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
72 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sept 1, 1926 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Severna Park | | | 10d. Inside City Limits
1 Yes 2 No | |
| 10e. Street and Number
223 McKeon Road | | | | 10f. Zip Code
21146 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: 1944-46 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+)
5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Electrical Engineer | | | 16b. Kind of Business/Industry
BGE Power Company | |
| 17. Father's Name (First, Middle, Last)
William Bartlett | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Anna Miller | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mary Bartlett / wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
223 McKeon Road, Severna Park, MD 21146 | | | | |
| 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD Veterans Cemetery | | Date
May 20 1999 | | 20c. Location - City or Town, State
Crownsville, MD | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy., Severna Park, MD 21146 | | | | |
| 23a. Part I: Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Lung CANCER
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | Approximate Interval Between Onset and Death
10 months |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CONGESTIVE HEART FAILURE, ATRIAL FIBRILLATION, chronic OBSTRUCTIVE PULMONARY DISEASE | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | | |
| 24a. Was an autopsy performed?
1 Yes 2 No | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | | | | | |
| 25. Was case referred to medical examiner?
1 Yes 2 No | | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) | | | | | |
| 27. Manner of Death
1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | |
| | | | 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier
<i>[Signature]</i> | | | 29c. License number
D38687 | | 29d. Date signed (Month, Day, Year)
5/17/99 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
STEPHEN JAY KATZ, MD 139 OLD SOLOMON'S ISLAND RD ANNAPOLIS, MD 21401 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 20 1999 | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/funeral certificate.

MAY 10 1953

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17846

| | | | | | | | | |
|--|--|---|--|--|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Clyde Edison Bowman | | | | 2. Date of Death
Month Day Year
May 20, 1999 | | 3. Time of Death
12:45 a.m. | |
| | 4a. Facility Name (If not institution, give street and number)
Sacred Heart Hospital | | | | 4b. City, Town, or Location of Death
Cumberland | | 4c. County of Death
Allegany | |
| Funeral
Director | 5. Social Security Number
214-07-6707 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
91 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Apr 26, 1908 | | 9. Birthplace (State or Foreign Country)
Pennsylvania |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
Garrett | | 10c. City, Town or Location
Grantsville | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
175 Meadowview Drive | | | | 10f. Zip Code
21536 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1942-45 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Farmer | | 16b. Kind of Business/Industry
Farming | | |
| 17. Father's Name (First, Middle, Last)
Edison Bowman | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Olive Blough | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Alice Smith/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
175 Meadowview Dr., Grantsville, MD 21536 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Grantsville Cem. | | 20c. Date
May 22, 1999 | | 20d. Location - City or Town, State
Grantsville, MD | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Newman Funeral Homes, P.A., P.O. Box 275
179 Miller St., Grantsville, MD 21536 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. SEPTIC SHOCK
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Approximate Interval Between Onset and Death
Two days. | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CORONARY ARTERY DISEASE
CONGESTIVE HEART FAILURE
DIABETES MELLITUS, Cerebro VASCULAR ACCIDENT | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
26907 | | 29d. Date signed (Month, Day, Year)
May 20, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Sidhu, Harjit M.D. - 925 Bishop Walsh Rd. Cumberland, MD 21502 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 21 1999 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5+IVA

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17867

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN ADRIAN BRANDON

2. Date of Death

Month Day Year
May 18, 1999

3. Time of Death

9:30 p.m.

4a. Facility Name (If not institution, give street and number)

Garrett Memorial Hospital

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

Funeral
Director

5. Social Security Number

309-32-3251

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10/19/30

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

WV

10b. County

Preston

10c. City, Town or Location

Terra Alta

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

103 Mayer Avenue

10f. Zip Code

26764

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Trucking

17. Father's Name (First, Middle, Last)

John S. Brandon

18. Mother's Name (First, Middle, Maiden Surname)

Helen Webb Brandon

19a. Informant's Name/Relationship (Type, Print)

Helen Brandon

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

103 Mayer Avenue, Terra Alta, WV 26764

20a. Method of Disposition

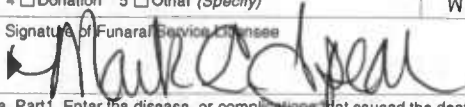
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

WV National Cemetery 5/21/99 Pruntytown, WV

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Arthur H. Wright Funeral Home
105 Highland Avenue, Terra Alta, WV 2676423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. pneumonia

Approximate
Interval Between
Onset and Death

3-4 days

Due to (or as a consequence of):

status post cerebrovascular accident

several
months

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

atherosclerotic heart disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

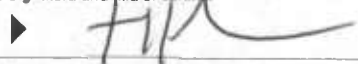
27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

DIS333

29d. Date signed (Month, Day, Year)

5/19/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas G. Johnson, M.D. 311 N. Fourth Street Oakland, MD 21550

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

11/10/19

11/10/19

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17848

| | | | | | | | | |
|---|---|---|---|--------------------------------------|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Naomi Auburn Bowser | | | | 2. Date of Death
Month May Day 14 Year 1999 | | 3. Time of Death
7:55 a.m. | |
| | 4a. Facility Name (If not institution, give street and number)
Goodwill Mennonite Home | | | | 4b. City, Town, or Location of Death
Grantsville | | 4c. County of Death
Garrett | |
| Funeral
Director | 5. Social Security Number
215-34-4401 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
96 Yrs. | If Under 1 Year
Months | If Under 24 Hrs.
Hours | 8. Date of Birth (Month, Day, Year)
Sept 5, 1902 | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
Garrett | 10c. City, Town or Location
Friendsville | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10a. Street and Number
1601 Friendsville-Addison Road | | | 10f. Zip Code
21531 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Own Home | | |
| | 17. Father's Name (First, Middle, Last)
Perry Savage | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ella Glotfelty | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Arvada B. Gidycz/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1830 York St., North Bloomfield, OH 44450 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Addison Cemetery, May 17, 1999 | | Date | | 20c. Location - City or Town, State
Addison, PA | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Newman Funeral Homes, P.A., P.O. Box 275
179 Miller St., Grantsville, MD 21536 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Athrosclerotic cardiovascular Disease
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death
1 month |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dysphagia
Aphasia | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
May 14, 1999 | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D25759 | | 29d. Date signed (Month, Day, Year)
May 14, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Walter K. Naumann, M.D. 106 Cemetery Road Accident, MD 21520 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1999 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 17849

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---|---|--|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Rose Carmela BRUNO | | | | 2. Date of Death
Month May Day 13 Year 1999 | | 3. Time of Death
5:32 AM | | |
| | 4a. Facility Name (If not Institution, give street and number)
Garrett County Memorial Hospital | | | | 4b. City, Town, or Location of Death
Oakland | | 4c. County of Death
Garrett | | |
| Funeral
Director | 5. Social Security Number
275-30-2043 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
85 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Nov. 26, 1913 | 9. Birthplace (State or Foreign Country)
New York | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD | | 10b. County
Garrett | | 10c. City, Town or Location
Oakland | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number
201 East Mason Street, Apartment 4 | | | | 10f. Zip Code
21550 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laundry Worker | | | 16b. Kind of Business/Industry
State Hospital | | |
| 17. Father's Name (First, Middle, Last)
Calagero ----- | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Bruno Carmela ----- Magestro | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Carol G. Paugh/Friend | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3756 Underwood Road, Oakland, Maryland 21550 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrett County Mem. Gds. | | Date
5/16/99 | | 20c. Location - City or Town, State
Oakland, Maryland | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Stewart Funeral Home
32 S. Second St., Oakland, MD 21550 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular Accident
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death
24-48 hr | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
H26154 | | 29d. Date signed (Month, Day, Year)
5/13/99 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. P. Daniel Miller, DO 69 Wolf Acres Drive, Oakland, Maryland 21550 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 14 1999 | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-17850

| | | | | | | | | |
|---|---|---|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Kenneth Allan Bantz | | | | 2. Date of Death
Month Day Year
MAY 9, 1999 | | 3. Time of Death
11:00 P.M. | |
| | 4a. Facility Name (If not Institution, give street and number)
Memorial Hospital & Medical Center | | | | 4b. City, Town, or Location of Death
Cumberland | | 4c. County of Death
Allegany | |
| Funeral
Director | 5. Social Security Number
216-76-1121 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
51 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 14, 1947 | | 9. Birthplace (State or Foreign Country)
WV |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
Garrett | | 10c. City, Town or Location
Bloomington | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
89 Hamill Avenue | | | | 10f. Zip Code
21523 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Unknown College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Handicapped | | | 16b. Kind of Business/Industry
Friends Aware | |
| 17. Father's Name (First, Middle, Last)
Kenneth N. Bantz | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Katherine Fazenbaker | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Joan Powers-Madsen/Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2 Barker Ct. Markham, Canada L3P3X8 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Philos Cemetery | | Date
5/13/99 | | 20c. Location - City or Town, State
Westernport, MD | | |
| 21. Signature of Funeral Service Licensee
F. Wayne B... | | | | 22. Name and Address of Facility
111 Church Street
Boal Funeral Home Westernport, MD 21562 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction
Due to (or as a consequence of):

b. Coronary Artery Disease
Due to (or as a consequence of):

c. Diabetes Mellitus, Type 1
Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death

10 Min.

10 Yrs

30 Yrs |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Downs Syndrome | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
N-A. Ranjithan | | | | 29c. License number
D 19318 | | 29d. Date signed (Month, Day, Year)
May 14th 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. N. Ranjithan, 517 Oldtown Road, Cumberland, MD 21502 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 13 1999 | | 32. Registrar's Signature
B. Sp... | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

KENNETH ALLAN BANTZ 216-76-1121

Division of Vital Records, P.O. Box 68760,

2

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17851

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Stanley Dennis Bonney

2. Date of Death

Month Day Year
May 9, 1999

3. Time of Death

12:30 PM

4a. Facility Name (If not institution, give street and number)

111 Riordan Road

4b. City, Town, or Location of Death

Westernport

4c. County of Death

Allegany

5. Social Security Number

212-24-0017

6. Sex

M 2 ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 23, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Md

10b. County

Allegany

10c. City, Town or Location

Westernport

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

111 Riordan Road

10f. Zip Code

21562

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW 213. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

Unknown

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Maintenance Electrician

16b. Kind of Business/Industry

Electrical

17. Father's Name (First, Middle, Last)

James Henry Bonney

18. Mother's Name (First, Middle, Maiden Surname)

G. Pearl Clark

19a. Informant's Name/Relationship (Type, Print)

Jeanne Bonney / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 Riordan Rd. Westernport, MD 21562

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Sunset Memorial Park

Date

5/12/99

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

F. Wayne Boal

22. Name and Address of Facility

111 Church Street
Boal Funeral Home Westernport, MD 2156223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Cardiomyopathy
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

10 yrs

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Coronary Artery Disease
Due to (or as a consequence of):

9 yrs

c. Chronic Obstructive Pulmonary Disease
Due to (or as a consequence of):

>20 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

A. Saweikis

29c. License number

WV 18383

29d. Date signed (Month, Day, Year)

5-10-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony A. Saweikis, M.D. PO Box 70 Keyser, WV 26726

31. Date filed (Month, Day, Year)

MAY 13 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

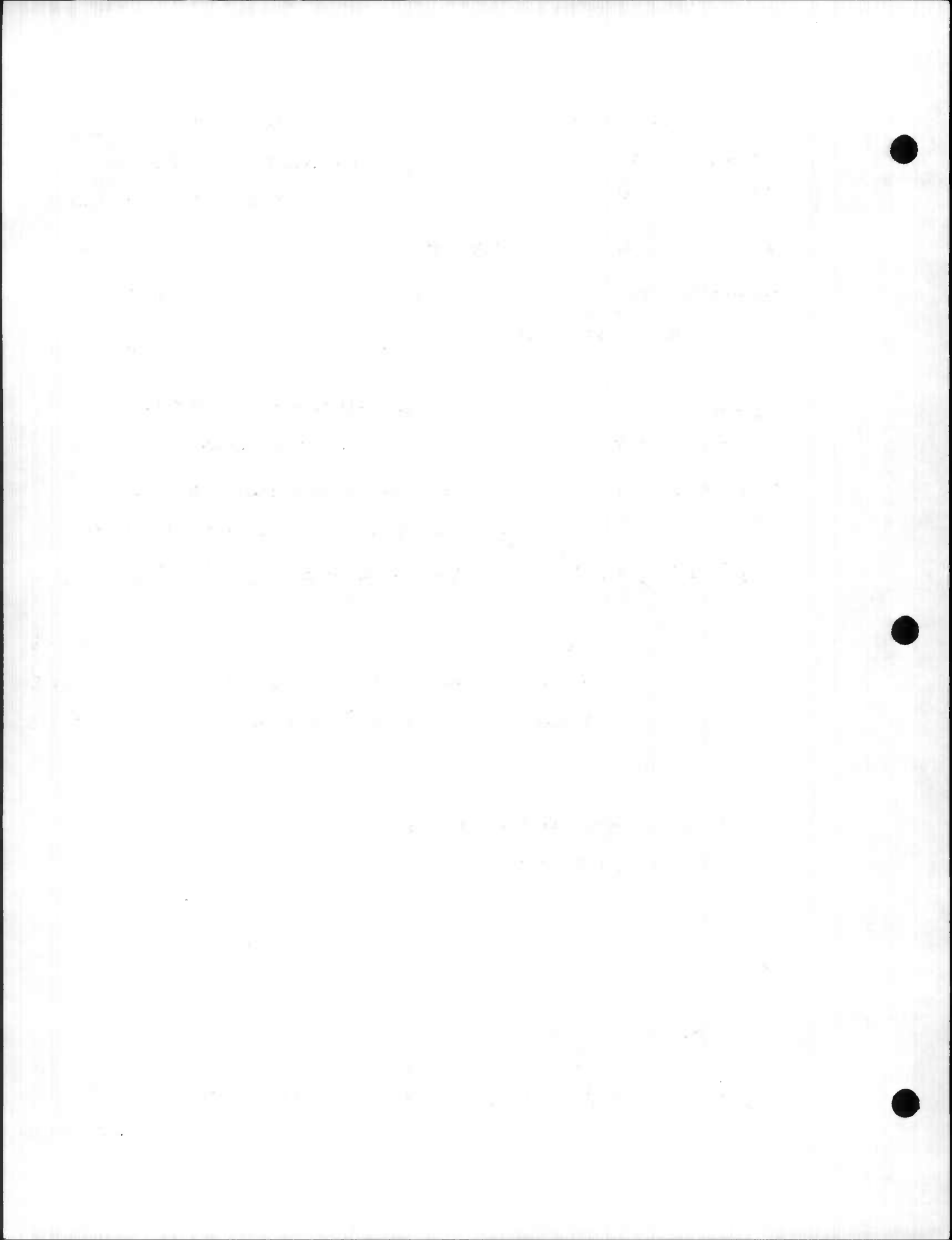
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17852

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jane Elizabeth Bassett

2. Date of Death

May 17 1999

3. Time of Death

2330

Funeral
Director

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

222-20-2354

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

July 8, 1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Somerset

10c. City, Town or Location

Princess Anne

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

28616 Deal Island Road

10f. Zip Code

21853

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Jennings Muir

18. Mother's Name (First, Middle, Maiden Surname)

Madelyn Ford

19a. Informant's Name/Relationship (Type, Print)

Arthur J. Bassett/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

28616 Deal Island Road, Princess Anne, Md. 21853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Peters U.M. Cemetery

Date

5/20/99

20c. Location - City or Town, State

Oriole, Maryland

21. Signature of Funeral Service Licensee

James Sherman M00295

22. Name and Address of Facility

Hinman Funeral Home
11673 Somerset Ave., Princess Anne, Md. 21853

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. cardiac arrhythmia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

20 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ischemic cardiomyopathy (old MI)

Due to (or as a consequence of):

13 years

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W B Horner MD

29c. License number

P13053

29d. Date signed (Month, Day, Year)

5/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William B. Horner, M.D. 100 POWELL ST SALISBURY, MD

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

Benjamin B. Sparks

State
Registrar

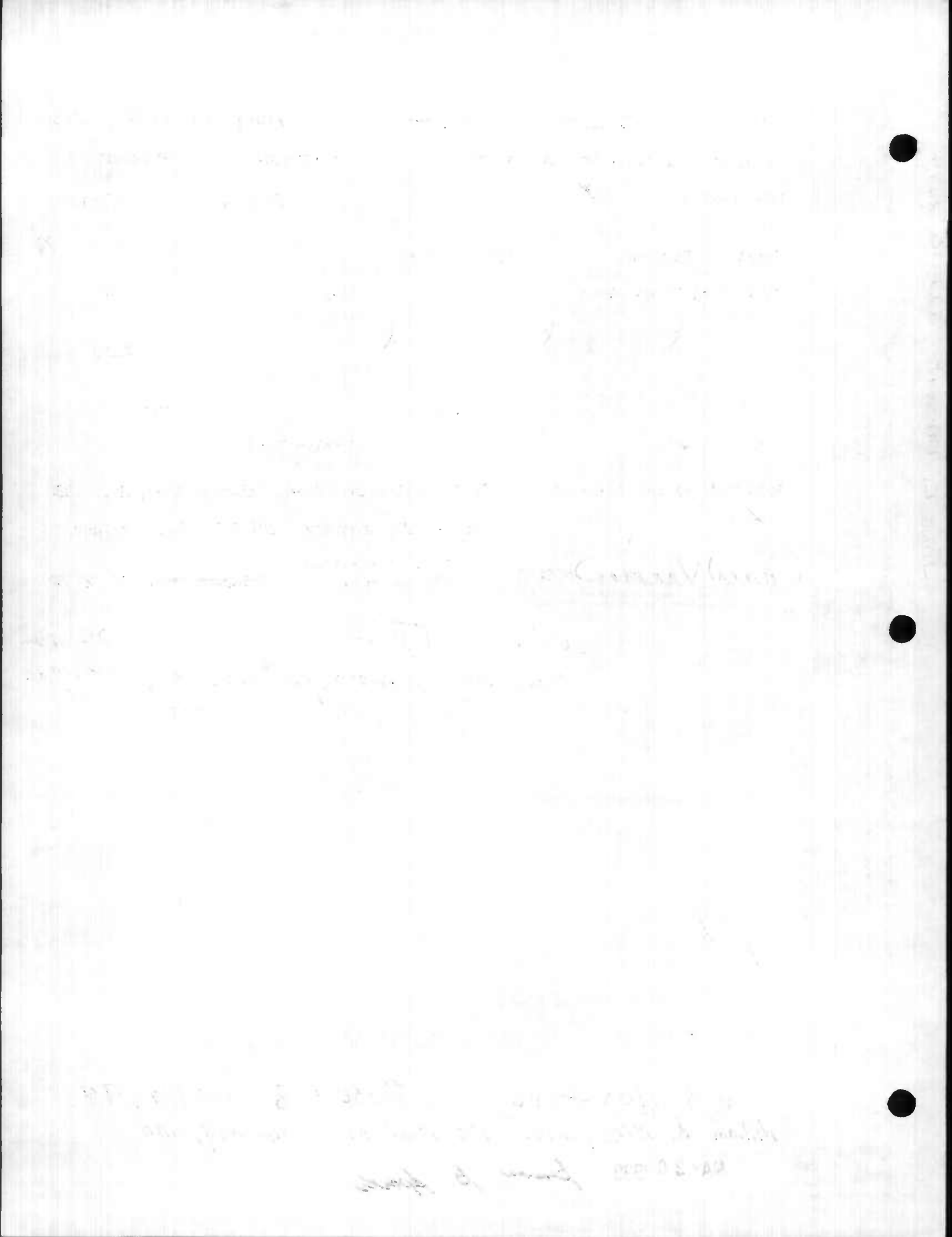
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 17853

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|---|---|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Shirley Constella Bryant</i> | | | | 2. Date of Death
Month <i>May</i> Day <i>13</i> Year <i>1999</i> | | 3. Time of Death
<i>0644</i> | | |
| | 4a. Facility Name (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
SALISBURY | | 4c. County of Death
WICOMICO | | |
| Funeral
Director | 5. Social Security Number
<i>218-30-1595</i> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>63</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>JAN. 3, 1936</i> | 9. Birthplace (State or Foreign Country)
<i>MD</i> | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
<i>MD</i> | | 10b. County
<i>WIC.</i> | | 10c. City, Town or Location
<i>Delmar</i> | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
<i>302 PENNSYLVANIA AVE.</i> | | | | 10f. Zip Code
<i>21875</i> | | 10g. Citizen of What Country?
<i>USA</i> | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>BLACK</i> | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>10</i> College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Campbell Soup</i> | | | | 16b. Kind of Business/Industry | | |
| | 17. Father's Name (First, Middle, Last)
<i>Charles Johnson</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Dorothy Milbourne</i> | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
<i>Alfreda Bryant, Daughter</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>2301 N. Washington St Wilm. Del. 19801</i> | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Capital Crematory</i> | | 20c. Date
<i>5/14/99</i> | | 20d. Location - City or Town, State
<i>DOVER DE.</i> | | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
<i>Bennie Smith F/H 917 W. ISABELLA ST SALIS. MD.</i> | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>ASCVD</i>
Due to (or as a consequence of):
<i>Heart Failure</i>

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28a. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
<i>D26040</i> | | 29d. Date signed (Month, Day, Year)
<i>5/13/99</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<i>Craig Schaefer, MD 551 Riverside Dr. Salisbury, MD</i> | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1999 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17854

| | | | | | | | | |
|---|--|--|---|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GEORGE DAY BROWN SR. | | | | 2. Date of Death
Month MAY Day 19 Year 1999 | | 3. Time of Death
4:10 PM. | |
| | 4a. Facility Name (If not institution, give street and number)
UNION HOSPITAL | | | | 4b. City, Town, or Location of Death
ELKTON | | 4c. County of Death
CECIL | |
| Funeral
Director | 5. Social Security Number
179-16-9392 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
81 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sept. 2, 1916 | | 9. Birthplace (State or Foreign Country)
Pa. |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD. | 10b. County
CECIL | 10c. City, Town or Location
Rising SUN MARYLAND | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
1881 TELEGRAPH RD. | | | 10f. Zip Code
21911 | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
FARMING | | | 16b. Kind of Business/Industry
FARMING | |
| | 17. Father's Name (First, Middle, Last)
George DAY BROWN SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ELLA MAE FIEDD | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
DONALD KEITH - NEPHEW | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
626 MARKET STREET OXFORD PA. 19363 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
NEW LONDON PRESBYTERIAN | | Date
5/21/99 | 20c. Location - City or Town, State
NEW LONDON PA. | | |
| | 21. Signature of Funeral Service Licensee
Edward McKee | | | | 22. Name and Address of Facility
GEE FUNERAL HOME 259 E. MAIN ST. ELKTON MD. | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Chronic Renal Failure
Due to (or as a consequence of):
b. CVD
Due to (or as a consequence of):
c. HTN
Due to (or as a consequence of):
d. | | | | | | | |
| | Approximate Interval Between Onset and Death
1 yr. > 5 yrs | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
Jose M. M.D. | | 29c. License number
D44716 | | 29d. Date signed (Month, Day, Year)
May 24, 1999 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOSE MORRIS MA 111 WEST HIGH ST STE 204 ELKTON MD | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 25 1999 | | | | 32. Registrar's Signature
B. Sparks | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17855

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ULTIMATE M. BRATTON-CLARKE

2. Date of Death

Month Day Year
May 13, 1999

3. Time of Death

12:00
Midnight

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

212-13-3797

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

14 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
September 13, 1984

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Oxon Hill

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

547 Wilson Bridge Drive, #B1

10f. Zip Code

20745

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Student

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Charles Henry Clarke, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Olivia Debra Bratton

19a. Informant's Name/Relationship (Type, Print)

Olivia Debra Bratton Corbett/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

547 Wilson Bridge Drive, #B1, Oxon Hill, Maryland 20745

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory

Date

05/18
1999

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perente

22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure - list only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gunshot Wound of Head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☒ Homicide

28a. Date of Injury

(Month, Day Year)

05-12-1999

28b. Time of Injury

M

5:00 P

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

A Home

28d. Describe how injury occurred

Subject was shot.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

504 Wilson Bridge drive, Oxon Hill, Maryland.

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Margarita Korell M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Margarita Korell M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 18 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17856

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SARAH BEST

2. Date of Death

Month
05Day
14Year
99

3. Time of Death

12:47 am

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

579-50-2357

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

April 4, 1934

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3016 Edgewood Road

10f. Zip Code

20895

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Montgomery Curry, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Simpkins

19a. Informant's Name/Relationship (Type, Print)

Sylvia Hunter/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12373 Quail Woods, Germantown, Maryland 20874

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Forest Hills Cemetery

Date

05/22

1999

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perante

22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Metastatic Breast Cancer

8 weeks

Due to (or as a consequence of):

b.

Hypertension

Due to (or as a consequence of):

c.

Diabetes Mellitus

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Shumacher M.D. PHYSICIAN

29c. License number

D40804

29d. Date signed (Month, Day, Year)

May 14 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ronald Shumacher, M.D. 2309 Shorefield Road, Silver Spring, Maryland 20902

31. Date filed (Month, Day, Year)

MAY 18 1999

32. Registrar's Signature

B. Jones

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 17857

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|---|---|---|--|--|--|-----------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Lola Zona Barrett | | | | 2. Date of Death
Month Day Year
May 15, 1999 | | | | 3. Time of Death
9:37AM | |
| | 4a. Facility Name (If not institution, give street and number)
Doctor's Community Hospital | | | | 4b. City, Town, or Location of Death
Lanham | | | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
266-14-4247 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
81 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| | 8. Date of Birth
(Month, Day, Year)
Jul. 27, 1917 | | 9. Birthplace (State or Foreign Country)
New York | | 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Annapolis | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
2566 Glen Cove | | 10f. Zip Code
21401 | | 10g. Citizen of What Country?
United States | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | | | | |
| | 17. Father's Name (First, Middle, Last)
Albino Zona | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Clementina Maggia | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
William Barrett/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2708 Church Creek Lane Edgewater, MD 21037 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veteran's | | 20c. Location - City or Town, State
5/20/1999 Cheltenham, MD | | | | | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
Robert E. Evans Funeral Home, Inc.
16000 Annapolis Road Bowie, MD 20715 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. PNEUMONIA RIGHT LUNG 2 DAYS
Due to (or as a consequence of):
b. PULMONARY EMBOLISM 3 WEEKS
Due to (or as a consequence of):
c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE 10 YEARS
Due to (or as a consequence of):
d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. Place of Death (Check only one)
Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>V. Singh</i> Attend Mng | | 29c. License number
019897 | | 29d. Date signed (Month, Day, Year)
5.16.99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
V. SINGH 7209A HANOVER PARKWAY GREENBELT MD. 20770 | | 31. Date filed (Month, Day, Year)
MAY 18 1999 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | |

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

99 17858

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17859

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert James Byrd

2. Date of Death

Month Day Year
May 20, 1999

3. Time of Death

2:08 am

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

216-40-8010

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 8, 1941

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

New Carrollton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8434 Ravenswood Road

10f. Zip Code

20784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Comptroller

16b. Kind of Business/Industry

Long Fence

17. Father's Name (First, Middle, Last)

George Maddox Montgomery Byrd

18. Mother's Name (First, Middle, Maiden Surname)

Vivian Edith Hart

19a. Informant's Name/Relationship (Type, Print)

Geraldine Mae Byrd - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8434 Ravenswood Road, New Carrollton, MD 20784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

05/22/99

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Claudette J. Gasch

22. Name and Address of Facility

Gasch's Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 2078123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Septic Shock

Approximate
Interval Between
Onset and Death

3 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

a. Due to (or as a consequence of):

Waldenström's macroglobulinemia

5 years

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day Year)

28b. Time of
injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

J. Selonick, M.D.

29c. License number

019838

29d. Date signed (Month, Day, Year)

5/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stuart E. Selonick, M.D. 900 Bestgate Rd. Annapolis, Md 21401

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

B. Apolito

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17860

| | | | | | | | | |
|--|--|---|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Patricia Ann Boyle | | | | 2. Date of Death
Month Day Year
MAY 12, 1999 | | 3. Time of Death
1301 | |
| | 4a. Facility Name (If not institution, give street and number)
FORT WASHINGTON HOSPITAL | | | | 4b. City, Town, or Location of Death
FORT WASHINGTON | | 4c. County of Death
PRINCE GEORGES | |
| Funeral
Director | 5. Social Security Number
166-30-1556 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
61 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 28, 1937 | |
| | 9. Birthplace (State or Foreign Country)
Pennsylvania | | 10. Usual Residence of Decedent
10a. State: Maryland 10b. County: Prince George's 10c. City, Town or Location: Fort Washington | | 10d. inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
1401 Washington Lane | | 10f. Zip Code
20744 | | 10g. Citizen of What Country?
U.S.A. | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 College (1-4 or 5+) | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | | | |
| 17. Father's Name (First, Middle, Last)
John Burns | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Jean Smith | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
William J. Boyle/Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1401 Washington La. Ft. Washington, MD 20744 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans Cemetery | | Date
5/18/99 | | 20c. Location - City or Town, State
Cheltenham, Maryland | | |
| 21. Signature of Funeral Service Licensee
<i>George P. Kalas</i> | | | | 22. Name and Address of Facility
George P. Kalas Funeral Home, P.A.
6160 Oxon Hill Rd. Oxon Hill, MD 20745 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| <p>a. <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u></p> <p>Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p> | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24e. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Mario F. Golue Jr</i> M.D. | | 29c. License number
D3395 | | 29d. Date signed (Month, Day, Year)
MAY 14, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARIO F. GOLUE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1999 | | 32. Registrar's Signature
<i>James B. Smith</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar
DHMH 16 Rev 6/95

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

~~SECRET~~

cm

Te'Nya Marie Briscoe

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, 27 PER MEO G772 6-14-99 WR.

Certificate of Death

Reg. No.

99 17861

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|--|---|---|--|-----------------------------------|---|--|-------------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Te'Nya Marie Briscoe | | | | 2. Date of Death
Month Day Year
May 23, 1999 | | 3. Time of Death
7:10 A.M. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Prince George's Hospital Center | | | | 4b. City, Town, or Location of Death
Cheverly | | 4c. County of Death
Prince George's | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
220-58-6401 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
Yrs. Months Days
3 15 | | 8. Date of Birth (Month, Day, Year)
February 8, 1999 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Capitol Heights | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10e. Street and Number
16 Daimler Drive | | | | 10f. Zip Code
20743 | | 10g. Citizen of What Country?
USA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 0 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
N/A | | | 16b. Kind of Business/Industry
N/A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
Timothy Thorpe | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Patricia Renee Briscoe | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Patricia R. Briscoe/mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16 Daimler Drive Capitol Heights, MD 20743 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. George Cemetery | | Date
5-29-99 | | 20c. Location - City or Town, State
Valley Lee, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MD
4308 Suitland Road Suitland, MD 20746 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td rowspan="4"> a. _____
Due to (or as a consequence of):

 b. _____
Due to (or as a consequence of):

 c. _____
Due to (or as a consequence of):

 d. _____ </td> <td colspan="7"> SUDDEN INFANT DEATH SYNDROME </td> </tr> <tr><td colspan="7"></td></tr> <tr><td colspan="7"></td></tr> <tr><td colspan="7"></td></tr> </table> | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. _____
Due to (or as a consequence of):

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____ | SUDDEN INFANT DEATH SYNDROME | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. _____
Due to (or as a consequence of):

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____ | SUDDEN INFANT DEATH SYNDROME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
May 24, 1999 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Laron Cooke, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 27 1999 | | 32. Registrar's Signature
 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

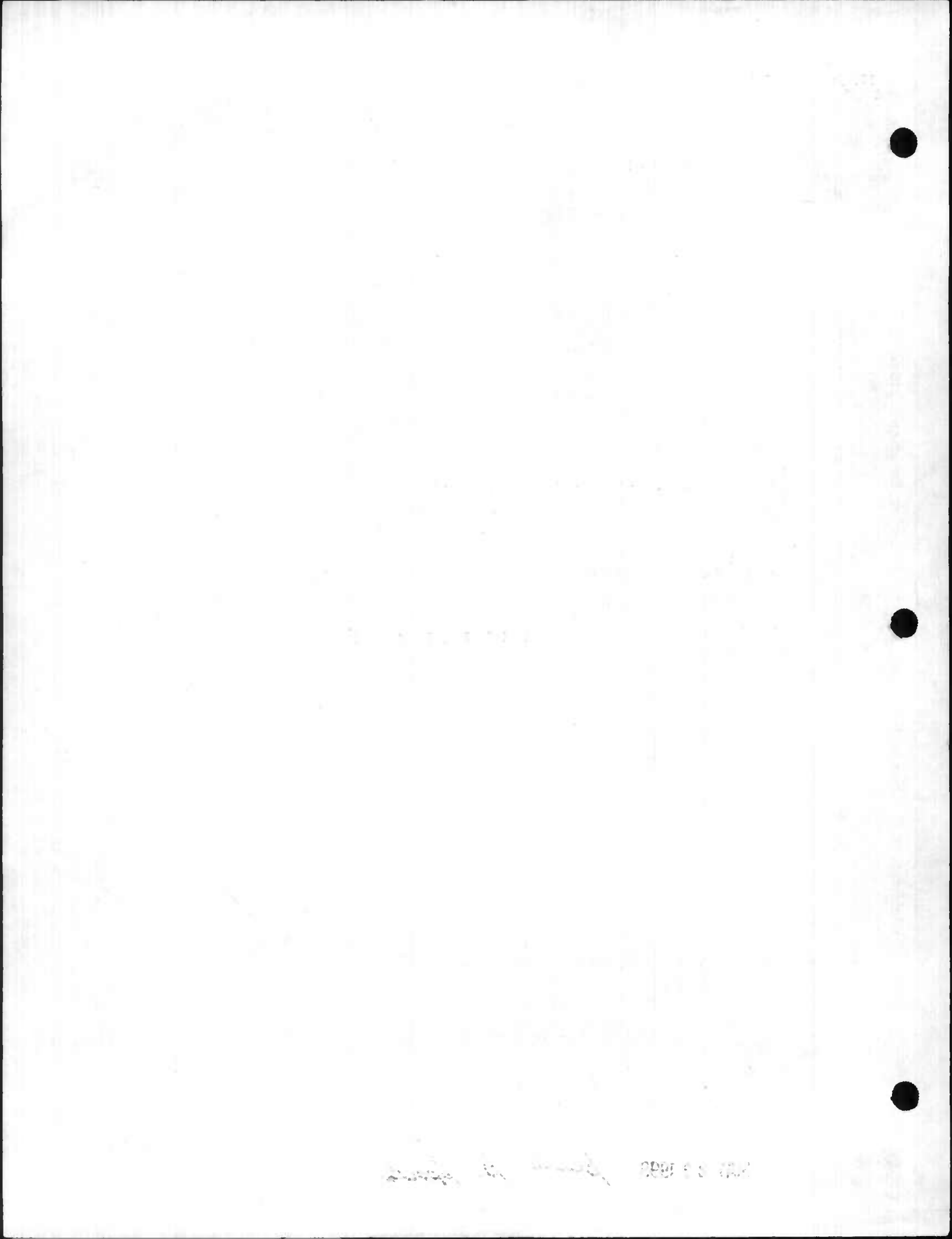
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17862

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

GEORGE PATTERSON BOWLING

2. Date of Death
Month Day Year

MAY 22 1999

3. Time of Death

9:45 AM

4a. Facility Name (If not institution, give street and number)

CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death

LA PLATA

4c. County of Death

CHARLES

5. Social Security Number

213-40-8536

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

99 Yrs.

8. Date of Birth (Month, Day, Year)

January 9, 1900

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

Charlotte

10d. inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10051 Trinity Church Road

10f. Zip Code

20622

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

Collega (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Farming

16b. Kind of Business/Industry

Farmer

17. Father's Name (First, Middle, Last)

Washington P. Bowling

18. Mother's Name (First, Middle, Maiden Sumame)

Mary Catherine Higgs Bowling

19a. Informant's Name/Relationship (Type, Print)

Guy Brent Bowling/Grandson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10051 Trinity Church Rd. Charlotte Hall MD 20622

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mary's Newport

Date

5/25/99

20c. Location - City or Town, State

Charlotte Hall, MD

21. Signature of Funeral Service Licensee

D. C. Echols M00945

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME P.A.
P.O. BOX 567 LA PLATA MD 20646

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Approximate Interval Between Onset and Death

minutes

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. L. Jenkins

29c. License number

D-33426

29d. Date signed (Month, Day, Year)

5/22/99

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

B. LARRY JENKINS M.D. 111 LAGRANGE AVENUE LA PLATA MARYLAND 20646

31. Date filed (Month, Day, Year)

MAY 25 1999

32. Registrar's Signature

B. L. Jenkins

State Registrar

George P. Bowling
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17863

| | | | | | | | | | |
|---|---|---|--|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DOROTHY REGINA COSTELLO | | | | 2. Date of Death
Month Day Year
May 17, 1999 | | 3. Time of Death
8:50 a.m. | | |
| | 4a. Facility Name (If not institution, give street and number)
Kensington-Algonquin | | | | 4b. City, Town, or Location of Death
Cumberland | | 4c. County of Death
Allegany | | |
| Funeral
Director | 5. Social Security Number
214-10-5111 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
85 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Aug 3, 1913 | 9. Birthplace (State or Foreign Country)
MD | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD | | 10b. County
Allegany | | 10c. City, Town or Location
Cumberland | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
1 Baltimore Street | | | | 10f. Zip Code
21502 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collage (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
secretary | | | 16b. Kind of Business/Industry
U.S. Government | | |
| 17. Father's Name (First, Middle, Last)
Joseph F. Sticher | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Nina R. Johnston | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mildred Garlitz-sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
613 Memorial Avenue; Cumberland, MD 21502 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
SS Peter Paul Cemetery | | Data
05/21 | | 20c. Location - City or Town, State
Cumberland, MD | | | |
| 21. Signature of Funeral Service Licensee
James F. Scarpelli | | | | 22. Name and Address of Facility
Scarpelli Funeral Home, P.A.
Cumberland, MD 21502 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Heart Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | Approximate Interval Between Onset and Death
8 years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No released | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Dr. George Breza, M.D. | | 29c. License number
D12532 | | 29d. Date signed (Month, Day, Year)
May 21, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. George Breza, M.D.; 912 Seton Drive; Cumberland, MD 21502 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 24 1999 | | | | 32. Registrar's Signature
B. Sparks | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17866

AMENDED ITEM #26 PER FH G776 10/13/99 AH

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
Mary Marcellane Cosgrove | | | | 2. Date of Death
Month May Day 23 Year 1999 | | 3. Time of Death
2:35PM | |
| 4a. Facility Name (If not institution, give street and number)
220 Sommerville Ave. | | | | 4b. City, Town, or Location of Death
Cumberland | | 4c. County of Death
Allegany | |
| 5. Social Security Number
215-10-3342 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
80 Yrs. | | 8. Date of Birth (Month, Day, Year)
Nov. 5, 1918 | |
| 9. Birthplace (State or Foreign Country)
MD | | 10a. State
MD | | 10b. County
Allegany | | 10c. City, Town or Location
Cumberland | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
220 Sommerville Ave. | | 10f. Zip Code
21502 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) Secretary | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | 16b. Kind of Business/Industry
Local Gov't. | | | |
| 17. Father's Name (First, Middle, Last)
Patrick Fahey | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mayme Fallon | | | |
| 19a. Informant's Name/Relationship (Type, Print)
James T. Cosgrove, Sr. (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12818 Pea Vine Run Rd. Cumb., MD 21502 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Patrick's Cemt. 5/26/99 | | 20c. Location - City or Town, State
Cumberland, MD | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Merritt-Adams Funeral Home, P.A.
404 Decatur St. Cumberland, Md. 21502 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic heart disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | |
| Approximate Interval Between Onset and Death
uk yrs | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D 09159 | | 29d. Date signed (Month, Day, Year)
May 23, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul Snow, M.D. 124 W. Third St. Cumberland, MD 21502 | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 25 1999 | | | | 32. Registrar's Signature
 | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17865

| | | | | | | | | |
|---|--|---|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LAWRENCE E. COPELAND | | | | 2. Date of Death
Month: MAY Day: 2 Year: 1999 | | 3. Time of Death
3:03 | |
| | 4a. Facility Name (If not institution, give street and number)
MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death
CUMBERLAND | | 4c. County of Death
ALLEGANY | |
| Funeral
Director | 5. Social Security Number
236-20-9818 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
93 Yrs. | If Under 1 Year
Months: Days: | If Under 24 Hrs.
Hours: Min. | 8. Date of Birth (Month, Day, Year)
May 13 1905 | 9. Birthplace (State or Foreign Country)
W.Va |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
W.Va | | 10b. County
Mineral | | 10c. City, Town or Location
Elk Garden | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
Shadyside Dr. | | | | 10f. Zip Code
26717 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 5 College (1-4 or 5+): | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Coal Miner | | | 16b. Kind of Business/Industry
Coal | |
| 17. Father's Name (First, Middle, Last)
John W. Copeland | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Anna Hickey | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Maude Copeland | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PO Box 252 Elk Garden WVa 26717 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
IOOF Cemetery | | Date
May 4 '99 | | 20c. Location - City or Town, State
Elk Garden WVa |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
David A. Burdock FH
710 Church St. Kitzmiller, Md 21538 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RESPIRATORY FAILURE
Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE LUNG DISEASE
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death

1 hour

20 years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OSTEOARTHRITIS, SEVERE | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 M.D. | | | | 29c. License number
D 23334 | | 29d. Date signed (Month, Day, Year)
MAY 10th, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DINESH B. SHAH, JOHNSON HEIGHTS MEDICAL BLDG., CUMBERLAND, MD 21502 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 11 1999 | | 32. Registrar's Signature
 | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17866

| | | | | | | | | | | |
|--|--|---|---|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Bessie Jane CANAN | | | | 2. Date of Death
Month Day Year
May 8, 1999 | | | | 3. Time of Death
7:16 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Garrett County Memorial Hospital | | | | 4b. City, Town, or Location of Death
Oakland | | | | 4c. County of Death
Garrett | |
| Funeral
Director | 5. Social Security Number
215-58-6718 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
87 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 11, 1911 | | 9. Birthplace (State or Foreign Country)
West Virginia | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
Garrett | | 10c. City, Town or Location
Oakland | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
1011 Sunnyside Road | | | | 10f. Zip Code
21550 | | 10g. Citizen of What Country?
USA | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th
College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | | 16b. Kind of Business/Industry
Home | | | |
| 17. Father's Name (First, Middle, Last)
Jasper Loman Hebb | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Villa Grace White | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Milton D. canan/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
566 Orendorf Road, Accident, Maryland 21520 | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fairview Cemetery | | Date
5/12/99 | | 20c. Location - City or Town, State
St. George, West VA | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Stewart Funeral Home
32 S. Second St., Oakland, MD 21550 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarct
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death
1/2 hour |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Breast cancer, Hypothyroid, Congestive Heart Failure

Dementia | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D26650 | | 29d. Date signed (Month, Day, Year)
5/10/99 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Margaret Kaiser, MD P.O. Box 486, Oakland, Maryland 21550 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 11 1999 | | 32. Registrar's Signature
 | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 17867

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CATHALEEN M. COULBOURN | | | | 2. Date of Death
Month Day Year
May 20, 1999 | | 3. Time of Death
7:55 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
5808 Charles Cannon Road | | | | 4b. City, Town, or Location of Death
Marion Station | | 4c. County of Death
Somerset | |
| Funeral
Director | 5. Social Security Number
216-46-5170 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
84 Yrs. | | 8. Date of Birth (Month, Day, Year)
August 20, 1914 | |
| | 9. Birthplace (State or Foreign Country)
Virginia | | 10a. State
Maryland | | 10b. County
Somerset | | 10c. City, Town or Location
Marion Station | |
| To Be Completed by
Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
5808 Charles Cannon Road | | | |
| | 10f. Zip Code
21838 | | | | 10g. Citizen of What Country?
U.S.A. | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) H.S. Graduate
College (1-4 or 5+) 3 Years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Registered Nurse | | 16b. Kind of Business/Industry
Medical | | | |
| | 17. Father's Name (First, Middle, Last)
Boyd L. Maddox | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Arie Carwile | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Lavern M. Driscoll (Sister) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
105 Glenlea Drive - Glen Burnie, MD 21060 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Paul's Cemetery | | 20c. Location - City or Town, State
5/23/99 Marion Station, MD | | | |
| | 21. Signature of Funeral Service Licensee
Robert H. Bradshaw, Jr. | | | | 22. Name and Address of Facility
Bradshaw & Sons Funeral Home
306 W. Main St. - Crisfield, MD 21817 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Acute Coronary Thrombosis
Due to (or as a consequence of):
b. Hypertension
Due to (or as a consequence of):
c. Coronary Atherosclerosis
Due to (or as a consequence of):
d. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Renal Failure
Intoxication | | | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by
Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier
W. Gill MD | | 29c. License number
D15715 | | 29d. Date signed (Month, Day, Year)
5.22.99 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William Gill, M.D. - 26423 Burton Avenue - Crisfield, MD 21817 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 25 1999 | | 32. Registrar's Signature
B. Sparks | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-17868

| | | | | | | | | |
|--|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HERMAN F. COOK, III | | | | 2. Date of Death
Month Day Year
MAY 18, 1999 | | 3. Time of Death
8:19 PM | |
| | 4a. Facility Name (If not institution, give street and number)
27 FUSTINGS AVENUE | | | | 4b. City, Town, or Location of Death
CATONSVILLE | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
219-40-3557 | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
57 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
NOV. 15, 1941 | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | 10b. County
WICOMICO | 10c. City, Town or Location
SALISBURY | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number
208 HALL DR. | | | 10f. Zip Code
21804 | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
NEVER WORKED | | 16b. Kind of Business/Industry
NONE | | | |
| | 17. Father's Name (First, Middle, Last)
HERMAN F. COOK, JR. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
BERNADINE CULLEN | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
EDMUND T. DELANEY | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
208 HALL DR. SALISBURY, MD 21804 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
PARSONS CEMETERY | | Date
5/22/99 | 20c. Location - City or Town, State
SALISBURY, MARYLAND | | |
| | 21. Signature of Funeral Service Licensee
<i>B. Keith Phyllis</i> | | | 22. Name and Address of Facility
705 E. MAIN ST.
BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <i>Hypertensive Arteriosclerotic Cardiovascular Disease</i>
Due to (or as a consequence of):
X
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Seizure Disorder</i> | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| State Registrar | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
<i>Dr. [Signature]</i> | | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
MAY 19, 1999 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>J. Allen Locke, MD</i> 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 20 1999 | | | | | | | | |
| 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DONALD

EUGENE

COLLINS

2. Date of Death
Month Day Year

May 14, 1999

3. Time of Death

1410

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

214-28-8782

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

March 25, 1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

202 W. Philadelphia Ave.

10f. Zip Code

21801

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1957-59

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)
4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Educator

16b. Kind of Business/Industry

Public School System

17. Father's Name (First, Middle, Last)

John Anthony Collins

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Pollitt

19a. Informant's Name/Relationship (Type, Print)

Diane M. Collins/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

202 W. Philadelphia Ave., Salisbury, MD 21801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Wicomico Memorial Park

Date

5/18/99

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

David H. Gompers

22. Name and Address of Facility

Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Coronary Artery Disease

Due to (or as a consequence of):

b. Atherosclerosis

Due to (or as a consequence of):

c. Diabetes Mellitus

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

years

years

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Jeff B. Hetherington, MD

29c. License number

36783

29d. Date signed (Month, Day, Year)

5/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeff B. Hetherington, MD PRIME SALISBURY MD 21804

31. Date filed (Month, Day, Year)

MAY 17 1999

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

DONALD COLLINS
214-28-8782
Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17870

| | | | | | | | | | | |
|--|--|--|---|---|--|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES RUFUS COOPER | | | | | 2. Date of Death
Month MAY Day 23 Year 1999 | | 3. Time of Death
11:05 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
115 Castlestone Drive | | | | | 4b. City, Town, or Location of Death
Elkton | | 4c. County of Death
Cecil | | |
| Funeral
Director | 5. Social Security Number
223-10-5486 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
83 Yrs. | | 8. Date of Birth (Month, Day, Year)
August 13, 1915 | | 9. Birthplace (State or Foreign Country)
Virginia | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Cecil | | 10c. City, Town or Location
Elkton | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
115 Castlestone Drive | | | | 10f. Zip Code
21921 | | 10g. Citizen of What Country?
United States | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Electrician Lineman | | | 16b. Kind of Business/Industry
Electricity | | | |
| | 17. Father's Name (First, Middle, Last)
Franklin Cooper | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Fannie Miller | | | | |
| To Be Completed by Funeral Director | 19a. Informant's Name/Relationship (Type, Print)
Katie Davidson Cooper / Spouse | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
115 Castlestone Drive, Elkton, MD 21921 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
North East Methodist Cem. | | Date
May 27 1999 | | 20c. Location - City or Town, State
North East, Maryland | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Crouch Funeral Home
127 South Main Street, North East, MD 21901 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Ureteral Cancer
Due to (or as a consequence of):

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | Approximate Interval Between Onset and Death
1 year |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
Monte Makous, MD | | 29c. License number
D-44783 | | 29d. Date signed (Month, Day, Year)
May 24, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MONTA MAKOUS, MD 111 West High Street, ELKTON, MD 21921 | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
MAY 24 1999 | | | | 32. Registrar's Signature
 | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-17871

| | | | | | | | | |
|---|---|---|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BETTY JEAN CHATMAN | | | | 2. Date of Death
Month 05 Day 14 Year 99 | | 3. Time of Death
4:45 pm | |
| | 4a. Facility Name (If not institution, give street and number)
6423 Hil-Mar Drive, #302 | | | | 4b. City, Town, or Location of Death
Forestville | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
225-68-9381 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
52 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 29, 1946 | |
| | 9. Birthplace (State or Foreign Country)
Suffolk, Virginia | | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Forestville | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number
6423 Hil-Mar Drive, #302 | | | | 10f. Zip Code
20747 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Pharmacy Manager | | 16b. Kind of Business/Industry
Private | | | |
| | 17. Father's Name (First, Middle, Last)
Chester Daniels | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Geneva White | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Euwon Chatman/Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6423 Hil-Mar Drive, #302, Forestville, Maryland 20747 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Carver Memorial Cemetery | | Date
05/19 1999 | | 20c. Location - City or Town, State
Suffolk, Virginia | |
| | 21. Signature of Funeral Service Licensee
Nancy A. Perceuti | | | | 22. Name and Address of Facility
J.B. JENKINS FUNERAL HOME
7474 Landover Road, Landover, Maryland 20785 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. glioblastoma multiforme
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
N/A | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Marcea Burnette | | 29c. License number
DD053328 | | 29d. Date signed (Month, Day, Year)
5/17/99 | | |
| 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)
6104 Old Branch Ave Temple Hills MD | | Marcea Burnette, M.D. | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 18 1999 | | 32. Registrar's Signature
[Signature] | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

[Faint, illegible text covering the majority of the page, possibly bleed-through from the reverse side.]

[Faint text at the bottom of the page, possibly a signature or date.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17872

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EVERLYN CLARK

2. Date of Death

MAY

19

1999

3. Time of Death

11:45 PM

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGE'S HOSPITAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

226-03-6225

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

8. Date of Birth

August 3, 1908

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Largo

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9805 Lakepointe Court

10f. Zip Code

20774

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
7th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Hostess

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Auguston White

18. Mother's Name (First, Middle, Maiden Surname)

Sallie Simpson

19a. Informant's Name/Relationship (Type, Print)

Evelyn Waters Clark/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12707 Heidi Marie Court, Upper Marlboro, Maryland 20774

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park Cemetery

Date

05/26
1999

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Belma Jenkins

22. Name and Address of Facility

J.B. Jenkins Funeral Home
7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Adenocarcinoma of the Colon.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Obstructive, metastatic cancer.

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient

2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. Alexander MD

29c. License number

D50016

29d. Date signed (Month, Day, Year)

May, 19 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BARBARA ALEXANDER 3001 Hospital Dr, Cheverly 20785

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

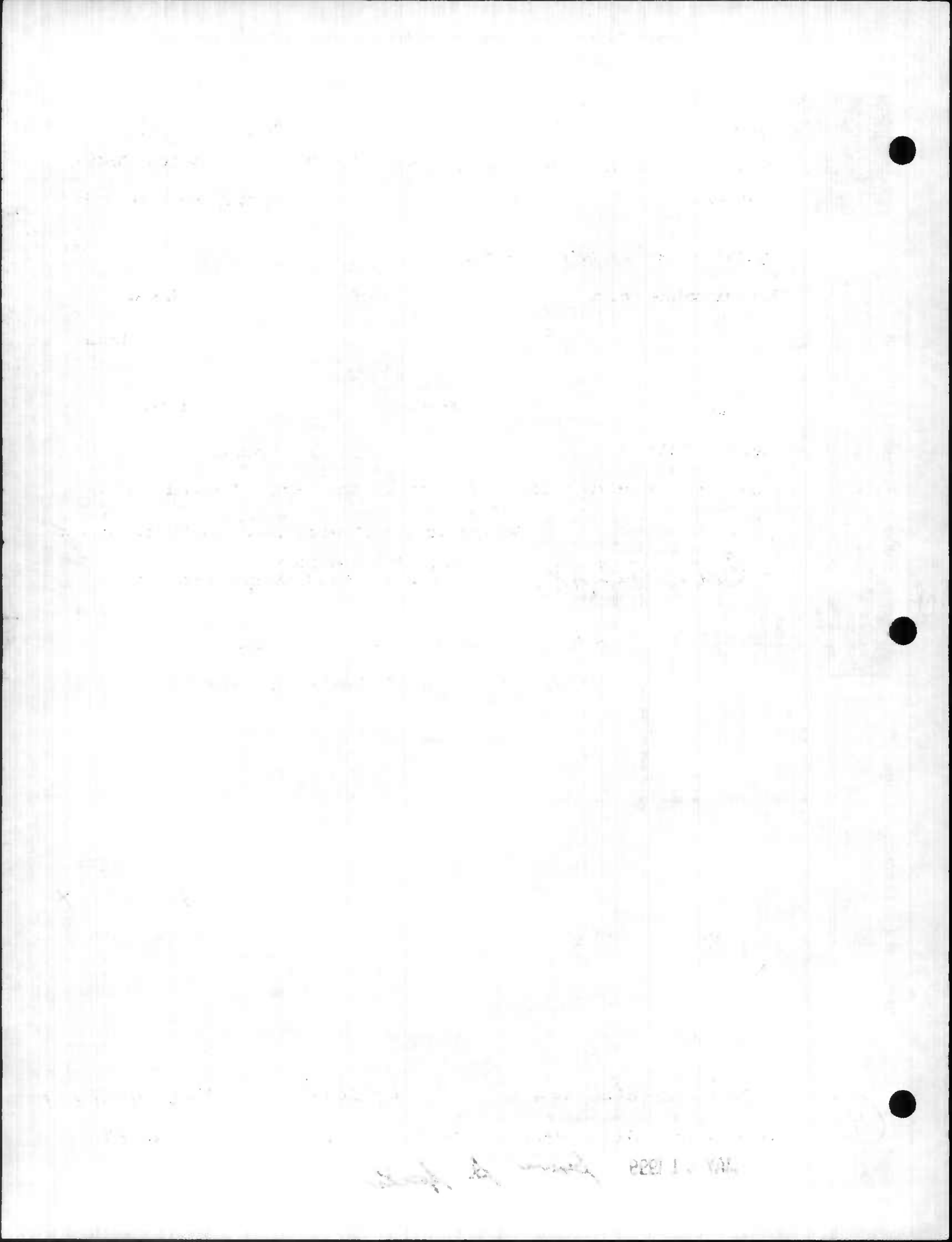
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17873

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BEVERLY MARY ANNE GODFREY DILDA COX

2. Date of Death

Month
MayDay
23Year
1999

3. Time of Death

3:18 PM

4a. Facility Name (If not institution, give street and number)

6615 Dobbins Place

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

Funeral
Director

5. Social Security Number

578-48-8948

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Mins

8. Date of Birth

(Month, Day, Year)

September 15, 1938

9. Birthplace (State or Foreign Country)

Wash, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

La Plata

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6615 Dobbins Place

10f. Zip Code

20646

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Granite Company

17. Father's Name (First, Middle, Last)

William Lee Godfrey

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Eleanor Millburn Godfrey

19a. Informant's Name/Relationship (Type, Print)

Kellie Bose / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7161 Snow Hill Rd. Salisbury, MD 21804

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

All Faith Cemetery

Date

5/27/99

20c. Location - City or Town, State

Mechanicsville, MD

21. Signature of Funeral Service Licensee

David C. Echols M00945

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME P.A.
P.O. BOX 567 LA PLATA, MD 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Pancreatic Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cardiopulmonary arrest

Due to (or as a consequence of):

5 min

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David C. Echols MD

29c. License number

D46246

29d. Date signed (Month, Day, Year)

May 24 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. A. MEELU, MD

WALDORF, MD 20603

State
Registrar

31. Date filed (Month, Day, Year)

MAY 25 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17874

| | | | | | | | | | | | |
|---|---|---------------------------|---|--|--|---|---|--|--|---------------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Thomas Richard Canter | | | | 2. Date of Death
Month: May, Day: 19, Year: 1999 | | | | 3. Time of Death
1:20 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
St. Mary's Nursing Center | | | | 4b. City, Town, or Location of Death
Leonardtown | | | | 4c. County of Death
St. Mary's | | |
| Funeral
Director | 5. Social Security Number
217-60-9912 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (in yrs. last birthday)
48 Yrs. | | 8. Date of Birth (Month, Day, Year)
September 2, 1950 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
St. Mary's | | 10c. City, Town or Location
Leonardtown | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
Washington Street | | | | 10f. Zip Code
20650 | | 10g. Citizen of What Country?
U.S.A. | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Carpenter | | | 16b. Kind of Business/Industry
Construction | | | | |
| 17. Father's Name (First, Middle, Last)
Thomas DeSales Canter | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Virginia Graves | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mary Virginia Faunce/Mother | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O.Box 306, Avenue, MD 20609 | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Charles Memorial Gardens | | | Date
5/24/99 | | 20c. Location - City or Town, State
Leonardtown, Maryland | | | |
| 21. Signature of Funeral Service Licensee
<i>Michael L. Gardiner</i> | | | | | 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. <i>Carcinomatous Colon Cancer</i>
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Approximate Interval Between Onset and Death
<i>months</i>
<i>1 yr.</i> | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<i>K.A.</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | 29b. Signature and Title of certifier
<i>James Patrick Jarboe MD</i> | | | | | 29c. License number
<i>D 06419</i> | |
| | | | | | 29d. Date signed (Month, Day, Year)
<i>5-20-99</i> | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
James Patrick Jarboe, MD Hollywood, Maryland 20636 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>MAY 20-1999</i> | | | | | 32. Registrar's Signature
<i>G. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

10-17-1944

10-17-1944

10-17-1944

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10-17-1944

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17875

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
Mary Lucy Chase | | | | 2. Date of Death
Month Day Year
May 21, 1999 | | 3. Time of Death
10:30 AM | |
| 4a. Facility Name (If not institution, give street and number)
40615 Kavanagh Road | | | | 4b. City, Town, or Location of Death
Mechanicsville | | 4c. County of Death
St. Mary's | |
| 5. Social Security Number
216-22-2982 | | 6. Sex
1 M 2 F | | 7. Age (In yrs. last birthday)
72 Yrs. | | 8. Date of Birth (Month, Day, Year)
December 23, 1926 | |
| 9. Birthplace (State or Foreign Country)
St. Mary's | | 10a. State
Maryland | | 10b. County
St. Mary's | | 10c. City, Town or Location
Mechanicsville | |
| 10d. Inside City Limits
1 Yes 2 No | | 10e. Street and Number
40615 Kavanagh Road | | 10f. Zip Code
20659 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
1 Yes 2 No | | 14. Race - American Indian, Black, White, etc.
Black | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | 17. Father's Name (First, Middle, Last)
John Edward Queen | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Effie Somerville | | 19a. Informant's Name/Relationship (Type, Print)
Cynthia E. Murray/Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
305 34th Street SE, Apt 2, Washington D.C. 20019 | | 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Queen of Peace Cemetery | | 20c. Date
5/24/99 | | 20d. Location - City or Town, State
Helen, MD | | 21. Signature of Funeral Service Licensee
 | |
| 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, MD 20650 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Acute Myocardial Infarction | | Approximate Interval Between Onset and Death
minutes | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | |
| 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atrial fibrillation
Hypertension | | 24a. Was an autopsy performed?
1 Yes 2 No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | | 25. Was case referred to medical examiner?
1 Yes 2 No | |
| 26. Place of Death (Check only one)
1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) | | 27. Manner of Death
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year)
May 21, 1999 | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
1 Yes 2 No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Dr. Jamie Boyd, MD | | 29c. License number
819917 | | 29d. Date signed (Month, Day, Year)
5/25/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Jamie Boyd, MD
California, MD. 20619 | | 31. Date filed (Month, Day, Year)
MAY 25 1999 | | 32. Registrar's Signature
 | | 33. State Registrar | |

To Be Completed by Funeral Director

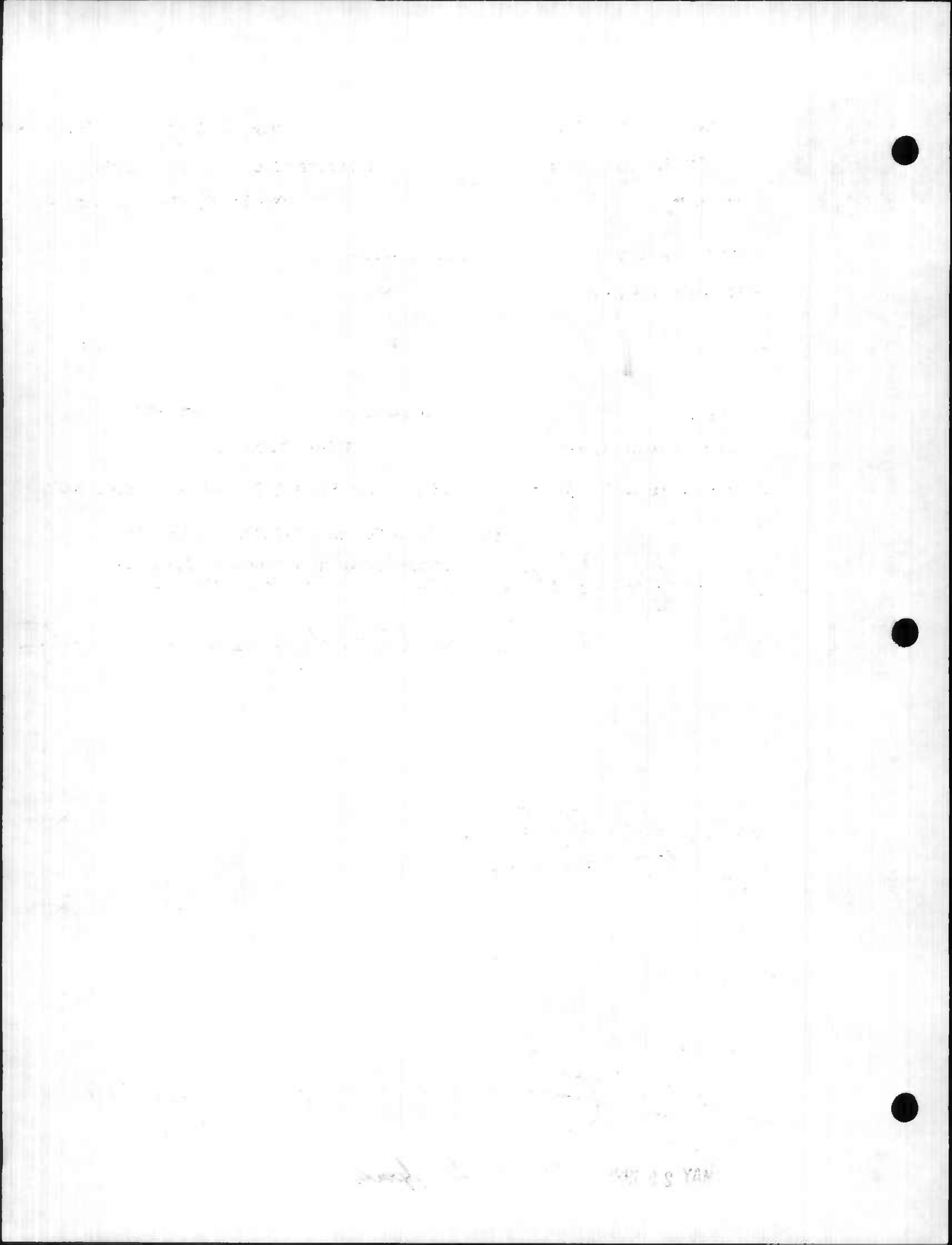
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 33a or 33a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17876

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

DOROTHY ANNE DELSIGNORE

2. Date of Death

Month Day Year
MAY 11 1999

3. Time of Death

13:24

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Baltimore

5. Social Security Number

239-40-7503

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
4/25/1931

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

WV

10b. County

Grant

10c. City, Town or Location

Gormanian

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

P.O. Box 87

10f. Zip Code

26720

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Charles ----- Barber

18. Mother's Name (First, Middle, Maiden Summa)

Blanche ----- (Unknown)

19a. Informant's Name/Relationship (Type, Print)

Richard M. DelSignore/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17702 E. Wilson Rd., Oldtown, MD 21555

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

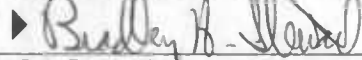
20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrett Co. Mem. Gardens 5/15/99 Oakland, Maryland

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Stewart Funeral Home

32 S. Second St., Oakland, MD 21550

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. INTRACTABLE METABOLIC ACIDOSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

12 HOURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. LIVER FAILURE

Due to (or as a consequence of):

02 DAYS

c. METASTATIC COLON CANCER

Due to (or as a consequence of):

07 MONTHS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

RES-000

29d. Date signed (Month, Day, Year)

May 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARK P. HAMLEN, MD 600 N. WOLFE ST, BALTIMORE, MD 21287

State
Registrar

31. Date filed (Month, Day, Year)

MAY 14 1999

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17877

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DAWN RENA

DAVIS

2. Date of Death
Month Day Year

MAY

16 1999

3. Time of Death

1123

4a. Facility Name (If not institution, give street and number)

JOHN HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

219-78-2417

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

28 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State
MD

10b. County

SOMERSET

10c. City, Town or Location

Princess Anne

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

31232 William RD

10f. Zip Code

21853

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Disabled

16b. Kind of Business/Industry

Disabled

17. Father's Name (First, Middle, Last)

LENARD A. DAVIS Sr.

18. Mother's Name (First, Middle, Maiden Surname)

LOUISE BALLARD

19a. Informant's Name/Relationship (Type, Print)

LOUISE DAVIS - MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

31232 William RD Princess Anne, MD 21853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT Olive Cemetery

Date

5-22-99

20c. Location - City or Town, State

Princess Anne, MD

21. Signature of Funeral Service Licensee

Anthony E. Ward

22. Name and Address of Facility

Anthony E. Ward Funeral Home
30639 Hampton Ave. Princess Anne, MD 21853

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

RENAL FAILURE

Due to (or as a consequence of):

4 DAYS

b.

RHABDOMYOLYSIS

Due to (or as a consequence of):

4 DAYS

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicidal 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ann Baw MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

MAY 16 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OLIVER BALON TOWER 110 JOHN HOPKINS HOSPITAL 600 NORTH WALK STREET BALTIMORE MARYLAND

31. Date filed (Month, Day, Year)

MAY 8 1 1999

32. Registrar's Signature

Bernice B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

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SECRET

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

#20c

State of Maryland / Department of Health and Mental Hygiene

Amended Item #20b per F.H. 5/24/99 jrd/WCH

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) **Otis Donald Dashield** 2. Date of Death Month **May** Day **19** Year **1999** 3. Time of Death **10:30PM**

4a. Facility Name (If not institution, give street and number) **22808 Capitalo Road** 4b. City, Town, or Location of Death **Tyaskin** 4c. County of Death **Wicomico**

5. Social Security Number **220-28-4977** 6. Sex ☒ M ☐ F 7. Age (In yrs. last birthday) **67** Yrs. 8. Date of Birth (Month, Day, Year) **April 21 1932** 9. Birthplace (State or Foreign Country) **Maryland**

Usual Residence of Decedent 10a. State **Maryland** 10b. County **Wicomico** 10c. City, Town or Location **Tyaskin** 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **22808 Capitalo Road** 10f. Zip Code **21865** 10g. Citizen of What Country? **U.S.A**

11. Marital Status ☐ Never Married ☒ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: **Black** 14. Race - American Indian, Black, White, etc. Specify: **Black**

15. Decedent's Education (Specify only highest grade completed) **Elementary/Secondary (0-12)** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Laborer** 16b. Kind of Business/Industry **None**

17. Father's Name (First, Middle, Last) **Gary Holbert Dashield** 18. Mother's Name (First, Middle, Maiden Surname) **Emma Conway**

19a. Informant's Name/Relationship (Type, Print) **Evelyn Dashield (Wife)** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **22808 Capitalo Road, Tyaskin, Md. 21865**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Springhill Memorial Garden Eastern Shore VA Cem.** Data **5/26/99** 20c. Location - City or Town, State **Hebron Hurlock, Md.**

21. Signature of Funeral Service Licensee **Bladys B. Stewart** 22. Name and Address of Facility **Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Metastatic Bladder Cancer** Due to (or as a consequence of): **lyr** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide 5. Pending investigation 6. Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☐ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier **[Signature]** 29c. License number **026278** 29d. Date signed (Month, Day, Year) **5-20-99**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **David Carroll, MD 145 E. Carroll St. Salisbury, MD 21801**

31. Date filed (Month, Day, Year) **MAY 20 1999** 32. Registrar's Signature **[Signature]**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17879

| | | | | | | | | | |
|---|---|---|---|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Mary B. Donahue | | | | 2. Date of Death
Month Day Year
May 22, 1999 | | 3. Time of Death
0215 | | |
| | 4a. Facility Name (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death
Baltimore Co. | | |
| Funeral
Director | 5. Social Security Number
208-28-1879 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
62 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
3-15-36 | 9. Birthplace (State or Foreign Country)
Bryn Mawr, PA. | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
DE | | 10b. County
Sussex | | 10c. City, Town or Location
Milton | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
RR # 4 Box 284G | | | | 10f. Zip Code
19968 | | 10g. Citizen of What Country?
US | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own | | | | |
| | 17. Father's Name (First, Middle, Last)
John McQuaid | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Elsie Millman | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
William A. Donahue | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RR #4 Box 284G Milton, DE. 19968 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ellendale Cem | | Date
5-26-99 | | 20c. Location - City or Town, State
Ellendale, DE | | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
Rogers Funeral Home
301 Lakeview Ave., Milford, DE. 19963 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. necrotic intestine
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
pancreatic mass | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> MD | | | | 29c. License number
RES-000 | | 29d. Date signed (Month, Day, Year)
May 22, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jorge D. Salazar, MD
600 North Wolfe Street
Baltimore, Maryland 21287 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 25 1999 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John P. Daly, Jr.

2. Date of Death

May 22, 1999

3. Time of Death

9:28 PM

4a. Facility Name (If not institution, give street and number)

412 Delaware Avenue

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

222-03-9339

6. Sex

12 M 2 F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 28, 1917

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

412 Delaware Ave.

10f. Zip Code

21921

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Lieutenant Colonel

16b. Kind of Business/Industry

US Air Force

17. Father's Name (First, Middle, Last)

John P. Daly, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Kathryn Doyle

19a. Informant's Name/Relationship (Type, Print)

Nell E. Daly/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

412 Delaware Ave. Elkton, MD 21921

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Del Vet Cemetery

Date

5-26-99

20c. Location - City or Town, State

Bear, Delaware

21. Signature of Funeral Service Licensee

Richard L. Goodie

22. Name and Address of Facility

R. T. Foard Funeral Home, P. A.
111 S. Queen St., Rising Sun, MD 21911

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Leukemia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 1/2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation 6 Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

H. Farkas, MD

29c. License number

D15314

29d. Date signed (Month, Day, Year)

May 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. Farkas, MD VNA/Northern Chesapeake Hospice, Elkton, MD

31. Date filed (Month, Day, Year)

MAY 25 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17881

Physician
/Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
important: If item 27 is marked other than "natural", or items 23a or 23d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
FRANK VINCENT DIGIOVANNA | | | | 2. Date of Death
Month 05 Day 14 Year 99 | | 3. Time of Death
3:15PM | |
| 4a. Facility Name (If not institution, give street and number)
Villa Rosa Nursing Home | | | | 4b. City, Town, or Location of Death
Mitchellville | | 4c. County of Death
Prince Georges | |
| 5. Social Security Number
132-03-4026 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
87 Yrs. | | 8. Date of Birth (Month, Day, Year)
Jan. 25, 1912 | |
| 9. Birthplace (State or Foreign Country)
New York | | 10a. State
Maryland | | 10b. County
Prince Georges | | 10c. City, Town or Location
Bowie | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
13313 Yarland Lane | | 10f. Zip Code
20715 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Program Coordinator | | 16b. Kind of Business/Industry
Federal Government | | | |
| 17. Father's Name (First, Middle, Last)
Biagio DiGiovanna | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Maria Sanna | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Tom DiGiovanna/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5415 Heron Bay Cove Nanjemoy, Md. 20662 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cem. | | 20c. Location - City or Town, State
5-21-99 Silver Spring | | | |
| 21. Signature of Funeral Service Licensee
Shannon W. Ramirez | | 22. Name and Address of Facility
Beall Funeral Home | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Alzheimer's Disease | | Approximate Interval Between Onset and Death
yes | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Disease
Idiopathic Aneurysm | | 23c. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | |
| 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of Certifier
[Signature] | | 29c. License number
032261 | | 29d. Date signed (Month, Day, Year)
5-14-99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Richard J. Fellen | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 19 1999 | | | | 32. Registrar's Signature
[Signature] | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-17882

| | | | | | | | | | | | |
|--|--|---|--|--|--|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JULIA DUDLEY | | | | 2. Date of Death
Month Day Year
MAY 13, 1999 | | | | 3. Time of Death
9:50am | | |
| | 4a. Facility Name (If not institution, give street and number)
GLADYS SPELLMAN NURSING CENTER | | | | 4b. City, Town, or Location of Death
CHEVERLY | | | | 4c. County of Death
PRINCE GEORGES | | |
| Funeral
Director | 5. Social Security Number
237-18-5269 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
81 Yrs. | | 8. Date of Birth (Month, Day, Year)
APRIL 25, 1918 | | 9. Birthplace (State or Foreign Country)
NORTH CAROLINA | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
MD | | 10b. County
PRINCE GEORGES | | 10c. City, Town or Location
BRANDYWINE | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10a. Street and Number
7608 EARNSHAW DR. | | | | 10f. Zip Code
20613 | | | | 10g. Citizen of What Country?
UNITED STATES | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOUSE MANAGER | | | | 16b. Kind of Business/Industry
PRIVATE | | | |
| 17. Father's Name (First, Middle, Last)
JOE MINTZ | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MAMIE MCENTIRE | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
DOROTHY COTTON / NEICE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7608 EARNSHAW DR., BRANDYWINE, MD 20613 | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
FOREST LAWN MEMORIAL PARK 5-17-99 | | | | 20c. Location - City or Town, State
ASHVILLE, NC | | | | | |
| 21. Signature of Funeral Service Licensee
<i>Alex S. Pope Jr.</i> | | | | 22. Name and Address of Facility
ALEXANDER S. POPE FUNERAL HOME
5538 MARLBORO PIKE, FORESTVILLE, MD 20747 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. <i>Melanotic Carcinomatosis</i>
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>End stage Ch. obstructive Pulm. Disease</i>
<i>Failure to thrive / Cachexia</i>
<i>Severe Anemia</i> | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Dr. Ashai M.D.</i> | | | | 29c. License number
D48213 | | | | 29d. Date signed (Month, Day, Year)
5-14-99. | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N. ASHAI 4000 Mitchellville RD #220 Bowie MD 20716 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1999 | | | | 32. Registrar's Signature
<i>James B. Smith</i> | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17883

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Louise M. Davis

2. Date of Death

Month Day Year
May 13, 1999

3. Time of Death

8:46 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

577-01-6432

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 24, 1910

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3819 Nicholson Street

10f. Zip Code

20782

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Tabulator - Operator

16b. Kind of Business/Industry

NSA

17. Father's Name (First, Middle, Last)

William Everest Davis

18. Mother's Name (First, Middle, Maiden Surname)

Florence May Phillips

19a. Informant's Name/Relationship (Type, Print)

Betty J. Maske - Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3819 Nicholson Street, Hyattsville, MD 20782

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate Of Heaven Cemetery

Date

05/18/99

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

W B Gerson

22. Name and Address of Facility

Gasch's Funeral Home

4739 Baltimore Ave., Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Sepsis
Due to (or as a consequence of):b. right knee infection
Due to (or as a consequence of):c. central venous catheter infection
Due to (or as a consequence of):

d. pneumonia

Approximate
Interval Between
Onset and Death

one day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

paroxysmal atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

David Plotkin M.D.

29c. License number

D52481

29d. Date signed (Month, Day, Year)

May 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Plotkin M.D. 11120 New Hampshire Ave Suite 305 Silver Spring MD 20904

31. Date filed (Month, Day, Year)

MAY 17 1999

32. Registrar's Signature

B. Spotts

State
Registrar

Baltimore, Maryland 21215-0020

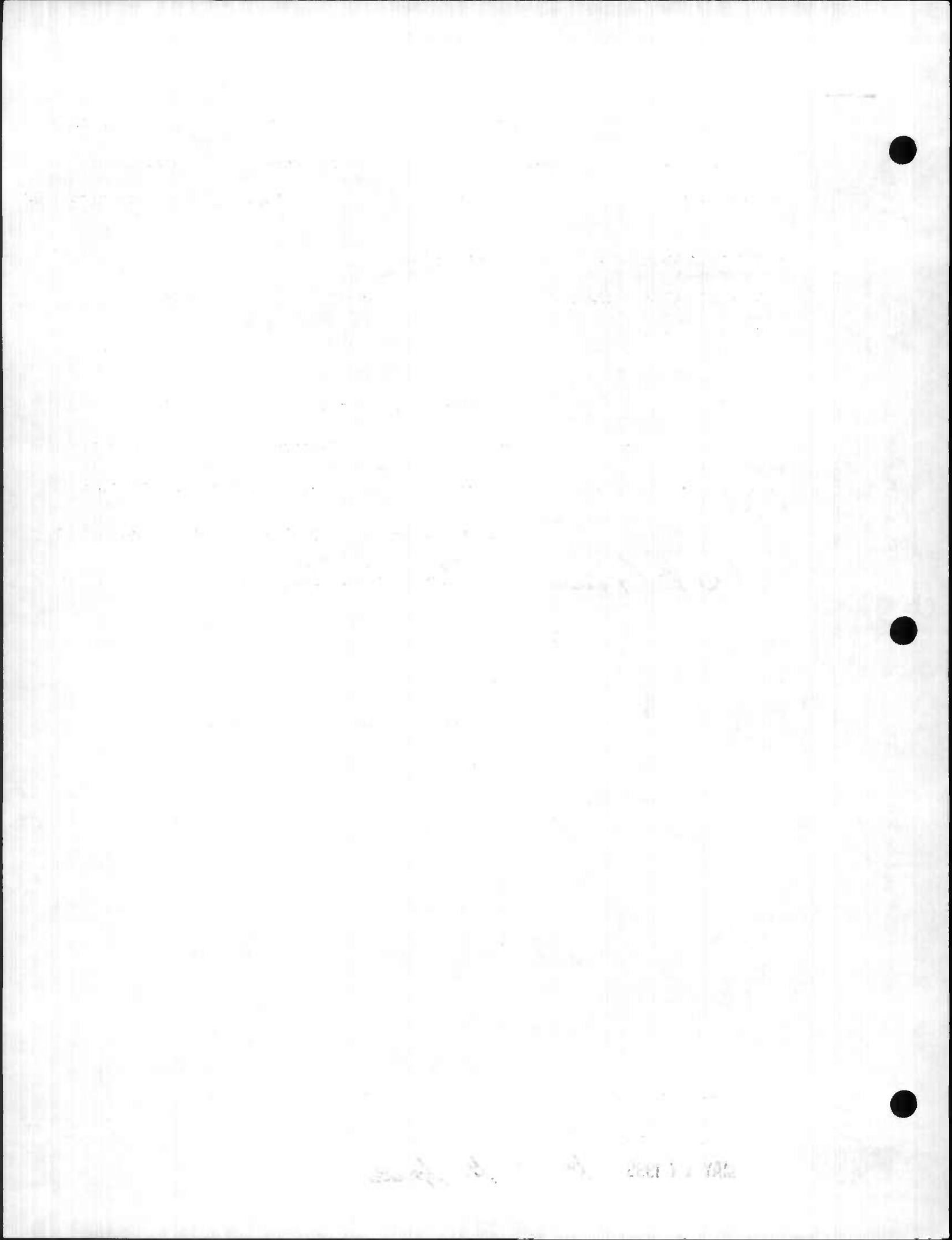
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-691-2025.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 17804

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Rodney W. Douglas Sr. | | | | 2. Date of Death
Month Day Year
May 21, 1999 | | 3. Time of Death
9:18 pm | |
| | 4a. Facility Name (If not institution, give street and number)
Southern Maryland Hospital | | | | 4b. City, Town, or Location of Death
Clinton | | 4c. County of Death
Prince Georges | |
| Funeral
Director | 5. Social Security Number
215-14-7055 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
84 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 1, 1915 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Prince George | | 10c. City, Town or Location
Aquasco | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
17601 Eagle Harbor Rd | | 10f. Zip Code
20608 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Farming | | 16b. Kind of Business/Industry
Agriculture | | | | |
| 17. Father's Name (First, Middle, Last)
Webster Douglas | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Maggie Douglas | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Pearl Douglas/ Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17601 Eagle Harbor Rd, Aquasco Maryland 20608 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Thomas CH Cem May 26, 99 | | 20c. Location - City or Town, State
Brandywine MD | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Adams Funeral Home P.A. Aquasco MD 20608 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. Metastatic Cancer Due to (or as a consequence of):
f. Cancer Prostate Due to (or as a consequence of):
g. Hypertension Due to (or as a consequence of):
h.

Approximate Interval Between Onset and Death
Months
5 year
1 yr | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Malnutrition | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury et Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
DD1923 | | 29d. Date signed (Month, Day, Year)
May 22 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
J. L. Johnson MD Waldorf, MD 20601 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 25 1999 | | 32. Registrar's Signature
 | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99-17885

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Bertha Louise Davis | | | | 2. Date of Death
Month Day Year
May 18, 1999 | | 3. Time of Death
11:20 PM | |
| | 4a. Facility Name (If not institution, give street and number)
46428 Midway Drive | | | | 4b. City, Town, or Location of Death
Lexington Park | | 4c. County of Death
St. Mary's | |
| Funeral
Director | 5. Social Security Number
423-38-7915 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
67 Yrs. | | 8. Date of Birth (Month, Day, Year)
December 4, 1931 | |
| | 9. Birthplace (State or Foreign Country)
Alabama | | 10a. State
Maryland | | 10b. County
St. Mary's | | 10c. City, Town or Location
Lexington Park | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
46428 Midway Drive | | 10f. Zip Code
20653 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Manager | | 16b. Kind of Business/Industry
Teen Center | | | |
| | 17. Father's Name (First, Middle, Last)
Ernest Stoddard | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Bertha Louise Osborne | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Theresa Troiano/Friend | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
45624 Ruthford Drive, Great Mills, MD 20634 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Immaculate Heart of Mary Cemetery | | Date
5/21/99 | | 20c. Location - City or Town, State
Lexington Park, Maryland | |
| | 21. Signature of Funeral Service Licensee
<i>Michael Kevin Anderson</i> | | | | 22. Name and Address of Facility
Matingley-Gardiner Funeral Home, PA.
P.O. Box 270, Leonardtown, Maryland 20650 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <i>Carcinomatosis</i>
Due to (or as a consequence of):
b. <i>Lung Cancer</i>
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Approximate Interval Between Onset and Death
1 yr
2 yrs | | | | | | | |
| | Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | | | | | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | | | | | | | | |
| State
Registrar | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>James P. Jarboe</i> | | 29c. License number
D06419 | | 29d. Date signed (Month, Day, Year)
5-20-99 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
James Patrick Jarboe, MD Hollywood, MD 20636 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 20 1999 | | 32. Registrar's Signature
<i>B. Sparks</i> | | | | | |
| | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten text at the top of the page, possibly a header or title.

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Handwritten text in the middle section of the page.

Handwritten text in the lower middle section of the page.

Handwritten text in the lower middle section of the page.

Handwritten text in the lower middle section of the page.

Handwritten text at the bottom of the page, possibly a signature or footer.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99-17886

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
John Carroll Dyson | | | | 2. Date of Death
Month Day Year
MAY 17, 1999 | | 3. Time of Death
5:44PM | |
| | 4a. Facility Name (If not institution, give street and number)
St. Mary's Hospital | | | | 4b. City, Town, or Location of Death
Leonardtown | | 4c. County of Death
St. Mary's | |
| Funeral
Director | 5. Social Security Number
213-22-1016 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
74 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
January 24, 1925 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
St. Mary's | | 10c. City, Town or Location
Park Hall | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
P.O. Box 281 | | | | 10f. Zip Code
20667 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Maintenance Man | | | 16b. Kind of Business/Industry
Self-Employed | |
| 17. Father's Name (First, Middle, Last)
Thomas Dyson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lucy E. Barnes | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Ernest Dyson/Brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 54, Park Hall, MD 20667 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Charles Memorial Gardens | | Date
5/21/99 | | 20c. Location - City or Town, State
Leonardtown, MD |
| 21. Signature of Funeral Service Licensee
<i>Michael Kevin Gardiner</i> | | | | 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, MD 20650 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <i>Acute Recurrent Cerebrovascular Accident</i>
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Hypertension + Congestive Heart Failure</i> | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Dr. James C. Boyd</i> | | | | 29c. License number
D19917 | | 29d. Date signed (Month, Day, Year)
5/18/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. JAMES C. BOYD CALIFORNIA, MD. 20619 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 20 1999 | | | | 32. Registrar's Signature
<i>B. Spahr</i> | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

NAME; JOHN CARROLL DYSON

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17887

| | | | | | | | | | | | |
|---|--|-------------------------------|---|--|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
FRANCES GRACE EASTMAN | | | | | | 2. Date of Death
Month Day Year
MAY 7, 1999 | | 3. Time of Death
1306 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
JASPER RILEY ROAD | | | | | | 4b. City, Town, or Location of Death
OAKLAND | | 4c. County of Death
GARRETT | | |
| Funeral
Director | 5. Social Security Number
315-12-4564 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
76 Yrs. | | 8. Date of Birth (Month, Day, Year)
MAR 25, 1923 | | 9. Birthplace (State or Foreign Country)
MISSISSIPPI | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
MD | | 10b. County
GARRETT | | 10c. City, Town or Location
OAKLAND | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
85 SAM EASTMAN ROAD | | | | 10f. Zip Code
21550 | | 10g. Citizen of What Country?
USA | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
ADMINISTRATIVE ASSISTANT | | | 16b. Kind of Business/Industry
US GOVERNMENT | | | | |
| 17. Father's Name (First, Middle, Last)
CLANCE RUSSELL GRACE | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MATILDA PAULINE MOECK | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
SAMUEL EASTMAN - HUSBAND | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
85 SAM EASTMAN RD. OAKLAND, MD 21550 | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
OMEGA CREMATORY | | Date
5/10/99 | | 20c. Location - City or Town, State
MORGANTOWN, WV | | | | |
| 21. Signature of Funeral Service Licensee
 M00167 | | | | 22. Name and Address of Facility
P.O. BOX 243
DURST FUNERAL HOME - OAKLAND, MD 21550 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular disease
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier
 Stephen S. Radentz, MD | | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
MAY 8, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 10 1999 | | | 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MarandaB. Evans

2. Date of Death

Month Day Year
May 22, 1999

3. Time of Death

2:25 a.m.

4a. Facility Name (If not institution, give street and number)

Edw. W. McCready Memorial Hospital

4b. City, Town, or Location of Death

Crisfield

4c. County of Death

Somerset

Funeral
Director

5. Social Security Number

220-26-3359

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

99 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
January 16, 1900

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Somerset

10c. City, Town or Location

Ewell

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3982 Smith Island Road

10f. Zip Code

21824

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Grade 6

College (1-4 or 5+)

- - - -

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

At Home

17. Father's Name (First, Middle, Last)

William Harrison Bradshaw

18. Mother's Name (First, Middle, Maiden Surname)

Angie Nora Evans

19a. Informant's Name/Relationship (Type, Print)

Emory L. Evans, Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

69 Fox Fire Drive - Port Deposit, MD 21904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ewell Church Cemetery

Date

5/26/99

20c. Location - City or Town, State

Ewell, MD

21. Signature of Funeral Service Representative

Robert H. Bradshaw, Jr.

22. Name and Address of Facility

Bradshaw & Sons Funeral Home
306 W. Main St. - Crisfield, MD 21817

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Approximate Interval Between Onset and Death

1 WK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

A SCVD

20 YRS.

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. T. Kanchana

29c. License number

D51086

29d. Date signed (Month, Day, Year)

5-22-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. T. Kanchana, McCready Hospital, Crisfield, Md. 21817

31. Date filed (Month, Day, Year)

MAY 25 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17689

| | | | | | | | | |
|--|--|-----------------------------|---|---|--|---|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Jerry A. Eckman, Sr. | | | | 2. Date of Death
Month May Day 17 Year 1999 | | 3. Time of Death
4:28 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Harford Memorial Hospital | | | | 4b. City, Town, or Location of Death
Havre de Grace | | 4c. County of Death
Harford | |
| Funeral
Director | 5. Social Security Number
139-36-8190 | | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
53 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Aug. 23, 1945 | 9. Birthplace (State or Foreign Country)
New Jersey |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Cecil | | 10c. City, Town or Location
North East | | | 10d. Inside City Limits
1 Yes 2 No | |
| 10e. Street and Number
74 Dora McMillan Lane | | | | 10f. Zip Code
21901 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: 1965-69 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Electrician | | | 16b. Kind of Business/Industry
Auto Manufacturing | |
| 17. Father's Name (First, Middle, Last)
Arthur Eckman | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Myrtle Nolan | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Constance M. Eckman/Wife | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
74 Dora McMillan Lane North East, MD 21901 | | | |
| 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cherry Hill Meth. Cemetery | | | 20c. Location - City or Town, State
5-21-99 Elkton, Maryland | | |
| 21. Signature of Funeral Service Licensee
<i>Richard L. Gordie</i> | | | | | 22. Name and Address of Facility
R. T. Foard Funeral Home, P. A.
111 S. Queen St., Rising Sun, MD 21911 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction
Due to (or as a consequence of):
b. Coronary Artery Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
hour
years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 Yes 2 No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | | |
| 25. Was case referred to medical examiner?
1 Yes 2 No | | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. Manner of Death
1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28d. Describe how injury occurred | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Sachdev S. MD</i> | | | | | 29c. License number
D23322 | | 29d. Date signed (Month, Day, Year)
5/18/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
S. S. Sachdev MD, 118 North St Suite 303, Elkton MD 21921. | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 19 1999 | | | 32. Registrar's Signature
<i>James B. Sparks</i> | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

May 17, 1999 4 pm

Eckman, Jerry A.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMEND ITEM: # 5 PER F.H. G773 7-17-99 WR.

Reg. No. 99 17890

EADS, LYLE W 5-8-99 1030P

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician / Medical Examiner

Funeral Director

| | | | | | | | | | |
|---|--|--|--|--|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)
Lyle Willis Eads | | | | | | 2. Date of Death
Month May Day 8 Year 1999 | | 3. Time of Death
10:30 PM | |
| 4a. Facility Name (If not institution, give street and number)
Charlotte Hall Veterans' Home | | | | 4b. City, Town, or Location of Death
Charlotte Hall | | 4c. County of Death
St. Mary's | | | |
| 5. Social Security Number
483-48-2540 | | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
82 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
June 29, 1916 | | 9. Birthplace (State or Foreign Country)
Iowa | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Florida | | 10b. County
Brevard | | 10c. City, Town or Location
Melbourne | | | 10d. Inside City Limits
1 Yes 2 No | | |
| 10e. Street and Number
1561 Valley Forge Lane | | | | 10f. Zip Code
32940 | | 10g. Citizen of What Country?
United States | | | |
| 11. Marital Status
1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Inspector | | | 16b. Kind of Business/Industry
U.S. Government | | |
| 17. Father's Name (First, Middle, Last)
David Eads | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Bertha McGonigle | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Diane Trautman, Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
39981 Mrs. Graves Road, Mechanicsville, MD 20650 | | | | | |
| 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Florida Memorial Gardens | | 20c. Location - City or Town, State
5/12/99 Rockledge, Florida | | | |
| 21. Signature of funeral home licensee
Edward N. Brinsfield, Jr. M00052 | | | | 22. Name and Address of Facility
Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

RESPIRATORY FAILURE
Due to (or as a consequence of):
CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
ATHEROSCLEROTIC HEART DISEASE
Due to (or as a consequence of):

Approximate Interval Between Onset and Death
FEW minutes to HR
HR'S
YRS | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | | | | | | 24a. Was an autopsy performed?
1 Yes 2 No | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE
PLEURAL EFFUSION | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 Yes 2 No | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | |
| 27. Manner of Death
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year)
May 8, 1999 | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
Dr. Eads
Attending | | | | 29c. License number
D-44436 | | 29d. Date signed (Month, Day, Year)
MAY 09 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ASHVINKUMAR PATEL 6 INDUSTRIAL PKWY WILMINGTON, MD 20601 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 13 1999 | | 32. Registrar's Signature
B. Sparks | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17891

| | | | | | | | | | | |
|---|--|--|---|--|--|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ROBERT LEE FISHER | | | | | | 2. Date of Death
Month Day Year
May 23, 1999 | | 3. Time of Death
1907 | |
| | 4a. Facility Name (If not institution, give street and number)
SACRED HEART HOSPITAL | | | | | | 4b. City, Town, or Location of Death
CUMBERLAND | | 4c. County of Death
ALLEGANY | |
| Funeral
Director | 5. Social Security Number
212 24 1139 | | 8. Sex
1 M 2 F | | 7. Age (In yrs. last birthday)
70 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| | 6. Date of Birth (Month, Day, Year)
JUNE 1 1928 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | Usual Residence of Decedent | | 10a. State
MARYLAND | | 10b. County
ALLEGANY | |
| 10c. City, Town or Location
FROSTBURG | | 10d. Inside City Limits
1 X Yes 2 No | | 10e. Street and Number
240 BRADDOCK ROAD | | 10f. Zip Code
21532 | | 10g. Citizen of What Country?
U.S. | | |
| 11. Marital Status
1 Never Married 2 X Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 X No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
TIRE BUILDER | | 16b. Kind of Business/Industry
TIRE BUILDING | | 17. Father's Name (First, Middle, Last)
ALBERT FISHER | | 18. Mother's Name (First, Middle, Maiden Surname)
RUTH MILLER | | 19a. Informant's Name/Relationship (Type, Print)
JOYCE FISHER / WIFE | | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
240 BRADDOCK ROAD, FROSTBURG, MD 21532 | | 20a. Method of Disposition
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
THE CUMBERLAND CREMATORY | | 20c. Date
5/24/99 | | 20d. Location - City or Town, State
CUMBERLAND, MD | | |
| 21. Signature of Funeral Service Licensee
Alan Sowers | | 22. Name and Address of Facility
SOWERS FUNERAL HOME, P.A.
60 W. MAIN ST., FROSTBURG, MD 21532 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Cardiac arrhythmia
Due to (or as a consequence of):
severe coronary disease
Due to (or as a consequence of):
Heart failure
Due to (or as a consequence of):
Heart failure | | Approximate Interval Between Onset and Death
30 (?) years | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 X No 3 Probably 4 Unknown | | |
| 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Leukemia; Anemia; diabetes; Heart failure | | 24a. Was an autopsy performed?
1 Yes 2 X No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No | | 25. Was case referred to medical examiner?
1 Yes 2 X No | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 X Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | |
| 27. Manner of Death
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Alan Sowers, MD | | 29c. License number
7707459 | | |
| 29d. Date signed (Month, Day, Year)
May 24, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
R. ESPINA, MD 902 Seton Drive, Cumberland | | 31. Date filed (Month, Day, Year)
MAY 25 1999 | | 32. Registrar's Signature
G. Sparks | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Amended # 206 5/26/99
Allegany County mlu

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17892

| | | | | | | | | | |
|---|---|---|---|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ada Belle Freno | | | | 2. Date of Death
Month Day Year
MAY 19 1999 | | 3. Time of Death
7:55 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
Sacred Heart Hospital | | | | 4b. City, Town, or Location of Death
Cumberlans | | 4c. County of Death
Allegany | | |
| Funeral
Director | 5. Social Security Number
214-34-1294 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
66 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
June 15, 1932 | 9. Birthplace (State or Foreign Country)
PA | | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD | | 10b. County
Allegany | | 10c. City, Town or Location
Cumberland | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number
515 Marshall St. | | | | 10f. Zip Code
21502 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
-----Homemaker----- | | 16b. Kind of Business/Industry | | | |
| 17. Father's Name (First, Middle, Last)
Ira Ryan | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Maude Clites | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Sherry Twigg (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14407 Brant Rd. Cresaptown, MD 21502 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sunset Memorial Park May 21, 1999 | | 20c. Location - City or Town, State
Cumberland, MD | | | | | |
| 21. Signature of Funeral Service Licensee
Robert C. Adams | | | | 22. Name and Address of Facility
Merritt-Adams Funeral Home, P.A.
404 Decatur St. Cumberland, Md. 21502 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Congestive heart failure
Due to (or as a consequence of):
b. coronary disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Neural failure
diabetes, type II
Hypoglycemia | | | | | | | | Approximate Interval Between Onset and Death
2 day
year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Neural failure
diabetes, type II
Hypoglycemia | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
R. Espina, MD | | | | 29c. License number
1703459 | | 29d. Date signed (Month, Day, Year)
MAY 20 1999 | | | |
| 30. Name and address of person who completed cause of death item 23a) (Type, Print)
R. ESPINA, MD 402 SETON DRIVE, CUMBERLAND MD | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 20 1999 | | 32. Registrar's Signature
B. Sparks | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 17893

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|--|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EVELYN BARRY FRYBERGER | | | | 2. Date of Death
Month Day Year
05 19 1999 | | 3. Time of Death
3:00 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
10814 Topbranch Lane | | | | 4b. City, Town, or Location of Death
Columbia | | 4c. County of Death
Howard | | |
| Funeral
Director | 5. Social Security Number
530 03 3879 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | 8. Date of Birth (Month, Day, Year)
02/04/1920 | | |
| | 9. Birthplace (State or Foreign Country)
California | | 10a. State
MD | | 10b. County
Howard | | 10c. City, Town or Location
Columbia | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
10814 Topbranch Lane | | 10f. Zip Code
21044 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretary | | 16b. Kind of Business/Industry
US Government | | 17. Father's Name (First, Middle, Last)
Cleveland Jefferson Barry | | 18. Mother's Name (First, Middle, Maiden Surname)
Annie Ethel Isaacs | |
| 19a. Informant's Name/Relationship (Type, Print)
Ann Yetter (daughter) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10814 Topbranch Lane/Columbia MD 21044 | | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | 20c. Location - City or Town, State
5/20/99 Alexandria VA | |
| 21. Signature of Funeral Service Licensee
Melanie Wilhelm Wagner | | 22. Name and Address of Facility
Advent Funeral & Cremation Services
Annapolis MD 21401 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Hepatic Insufficiency
Due to (or as a consequence of):
Liver Metastasis
Due to (or as a consequence of):
Cancer of Colon
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
1 mo.
9 mo.
9 mo. | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Hepatic Insufficiency
Due to (or as a consequence of):
Liver Metastasis
Due to (or as a consequence of):
Cancer of Colon
Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28b. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Martin O. Weltz | | 29c. License number
D23743 | |
| 29d. Data signed (Month, Day, Year)
5-19-99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Martin Weltz, MD 7525 Greenway Center Drive Greenbelt MD 20770 | | 31. Date filed (Month, Day, Year)
MAY 20 1999 | | 32. Registrar's Signature
B. Sparks | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

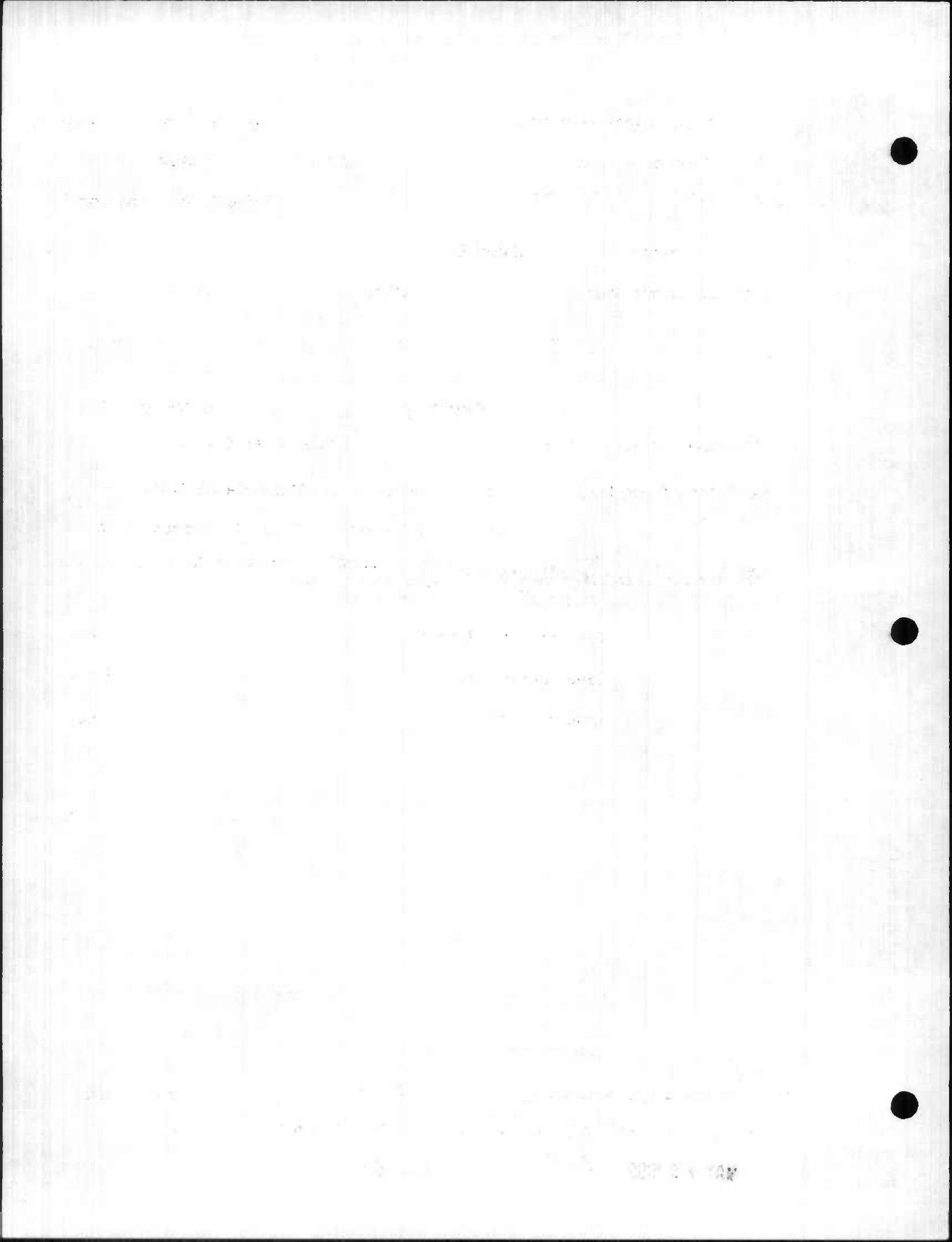
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17896

| | | | | | | | | | | | |
|--|--|--------------------------------|---|---|--|---------------------------------|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Keith D. Flagg | | | | 2. Date of Death
Month MAY Day 17 Year 1999 | | | | 3. Time of Death
1014 | | |
| | 4a. Facility Name (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
SALISBURY | | | | 4c. County of Death
WICOMICO | | |
| Funeral
Director | 5. Social Security Number
216-90-6972 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
32 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb 15, 1967 | | 9. Birthplace (State or Foreign Country)
MD | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
MD | | 10b. County
Wicomico | | 10c. City, Town or Location
Delmar | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number
9248 Claire Circle | | | | 10f. Zip Code
21875 | | | | 10g. Citizen of What Country?
U.S. | | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> 3 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Bartender/Manager | | | | 16b. Kind of Business/Industry
Restaurant/Hotel | | | |
| 17. Father's Name (First, Middle, Last)
James Brown | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Jeanette Flagg | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Jeanette Flagg/mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9248 Claire Circle, Delmar, MD 21875 | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Green Acres Mem Park | | | | 20c. Location - City or Town, State
5/22/99 Salisbury, MD | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Lewis N. Watson Funeral Home
1618 West Rd., Salisbury, MD 21801 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Respiratory & Renal failure
Due to (or as a consequence of):
b. Septic Shock
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24f. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
 | | | | 29c. License number
D47637 | | | |
| | | | | 29d. Date signed (Month, Day, Year)
5-17-99 | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph INZERILLO MD 262 Tilghman Rd. Salisbury Md. 21804 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 20 1999 | | | | 32. Registrar's Signature
 | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17895

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VIOLA FOSKEY

2. Date of Death

May 14 1999

3. Time of Death

1558

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

221-14-6834

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUNE 21, 1924

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

DELAWARE

10b. County

SUSSEX

10c. City, Town or Location

ELLENDALE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

305 MAIN ST.

10f. Zip Code

19941

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

BILL MCGINNIS

18. Mother's Name (First, Middle, Maiden Surname)

ELSIE TIMMONS

19a. Informant's Name/Relationship (Type, Print)

RALPH W. FOSKEY, SR. HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 260, ELLENDALE, DE 19941

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MC COLLEYS CEMETERY

Date

5-18-99

20c. Location - City or Town, State

GEORGETOWN, DE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

BERRY-SHORT FUNERAL HOME

119 NW FRONT ST., MILFORD, DE 19963

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

b. Atherosclerosis

Due to (or as a consequence of):

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Emphysema

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D36783 MD

29d. Date signed (Month, Day, Year)

May 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeffery R. Etkerton, MD. PRINC SALISBURY Maryland 21801

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

10

State Registrar

221-14-6834

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17896

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Cecelia Marie Fenwick

2. Date of Death

Month Day Year
MAY 24, 1999

3. Time of Death

11:20PM

4a. Facility Name (If not institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtwn

4c. County of Death

St. Mary's

Funeral
Director

5. Social Security Number

578-36-8177

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
February 4, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Lexington Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

47482 South Hampton Drive

10f. Zip Code

20653

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

Bus Station

17. Father's Name (First, Middle, Last)

Francis Gordon Fenwick

18. Mother's Name (First, Middle, Maiden Surname)

Marie Barber

19a. Informant's Name/Relationship (Type, Print)

Mary M. Gardner/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1433 Madison Avenue, Baltimore, MD 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Immaculate Heart of Mary Cemetery

Date

5/29/99

20c. Location - City or Town, State

Lexington Park, MD

21. Signature of Funeral Service Licensee

Michael K. Gardner

22. Name and Address of Facility

Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, MD 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. End stage CHF

Due to (or as a consequence of):

Approximate Interval Between Onset and Death
few months

b. End stage CAD.

Due to (or as a consequence of):

few months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Renal Failure

Due to (or as a consequence of):

few months

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Avani D. Shah

29c. License number

D 47066

29d. Date signed (Month, Day, Year)

5-25-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. AVANI D. SHAH HOLLYWOOD, MD. 20636

31. Date filed (Month, Day, Year)

MAY 25, 1999

32. Registrar's Signature

B. Spahr

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

NAME; CECELIA MARIE FENWICK

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17897

| | | | | | | | | |
|--|--|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HARDY FORD | | | | 2. Date of Death
Month MAY Day 18 , Year 1999 | | 3. Time of Death
10:43 am | |
| | 4a. Facility Name (If not Institution, give street and number)
WASHINGTON ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death
TAKOMA PARK | | 4c. County of Death
MONTGOMERY CO. | |
| Funeral
Director | 5. Social Security Number
579-12-1409 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
89 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
8-26-1909 | 9. Birthplace (State or Foreign Country)
GOLDSBORO, NC |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
DC | | 10b. County | | 10c. City, Town or Location
WASHINGTON | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
5810 5th STREET, NW | | | | 10f. Zip Code
20011 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
LABORER | | 16b. Kind of Business/Industry
NAVY YARD | | |
| 17. Father's Name (First, Middle, Last)
UNKNOWN | | | | 18. Mother's Name (First, Middle, Maiden Surname)
UNKNOWN | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
DELORES FORD - DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5810 5th STREET, NW WASH.DC 20011 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
LINCOLN MEMORIAL CEM. | | 20c. Location - City or Town, State
22-99 SUITLAND, MD | | 20d. Date
5- | | |
| 21. Signature of Funeral Service Licensee
<i>B.C. Taylor</i> | | | | 22. Name and Address of Facility
TAYLOR'S FUNERAL HOME
1722 NORTH CAPITOL ST., NW WASH.DC 20001 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Asystole
Due to (or as a consequence of):
b. Massive Heart Attack
Due to (or as a consequence of):
c. Atherosclerosis
Due to (or as a consequence of):
d. | | | | | | | | Approximate Interval Between Onset and Death

minutes

minutes

years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension / Stroke
aspiration pneumonia | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Rashid N. Nour</i> | | 29c. License number
D 39372 | | 29d. Date signed (Month, Day, Year)
May 18th 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
344 UNIVERSITY BLVD WEST, SUIT 324
SILVERSPRING MD 20901 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 21 1999 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

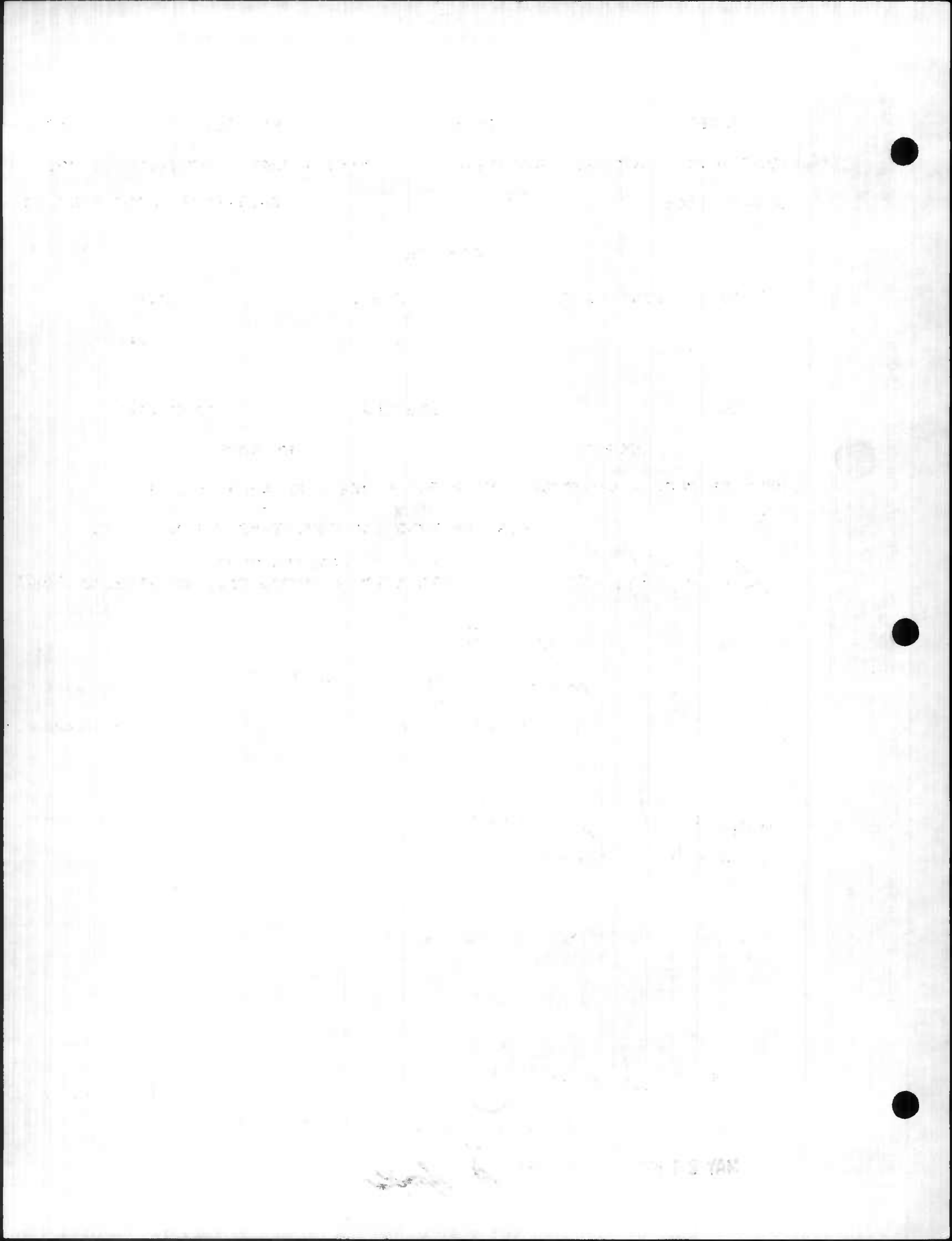
Division of Vital Records, P.O. Box 68760,

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Physician
/Medical
Examiner

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State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17898

| | | | | | | | | |
|--|---|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Verna Glenna Goss | | | | 2. Date of Death
Month Day Year
May 15, 1999 | | 3. Time of Death
7:25 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Annapolis Nursing & Rehabilitation Center | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
170-26-4102 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)
81 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
March 12, 1918 | 9. Birthplace (State or Foreign Country)
New York |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
West River | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
5339 Sweetwater Drive | | | | 10f. Zip Code
20778 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Production Worker | | | 16b. Kind of Business/Industry
Electronics | |
| 17. Father's Name (First, Middle, Last)
Charles Goss | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Carrie LaBar | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
B. Patrick Goss/ Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5339 Sweetwater Drive West River, MD 20778 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakemont Meml. Gardens | | 20c. Location - City or Town, State
Davidsonville, MD | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility
George P. Kalas Funeral Home
2973 Solomons Island Rd. Edgewater, MD 21037 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. <u>CARDIAC ARREST</u>
Due to (or as a consequence of):
b. <u>Cerebrovascular accident</u>
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>dysarthria</u>
<u>pneumonia</u> | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier | | 29c. License number
H538C3 | | 29d. Date signed (Month, Day, Year)
3/15/99 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Brian Kahan, M.D. 1610 West Street Suite 110 Annapolis, MD 21401 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 18 1999 | | | | 32. Registrar's Signature
B. Kahan | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17899

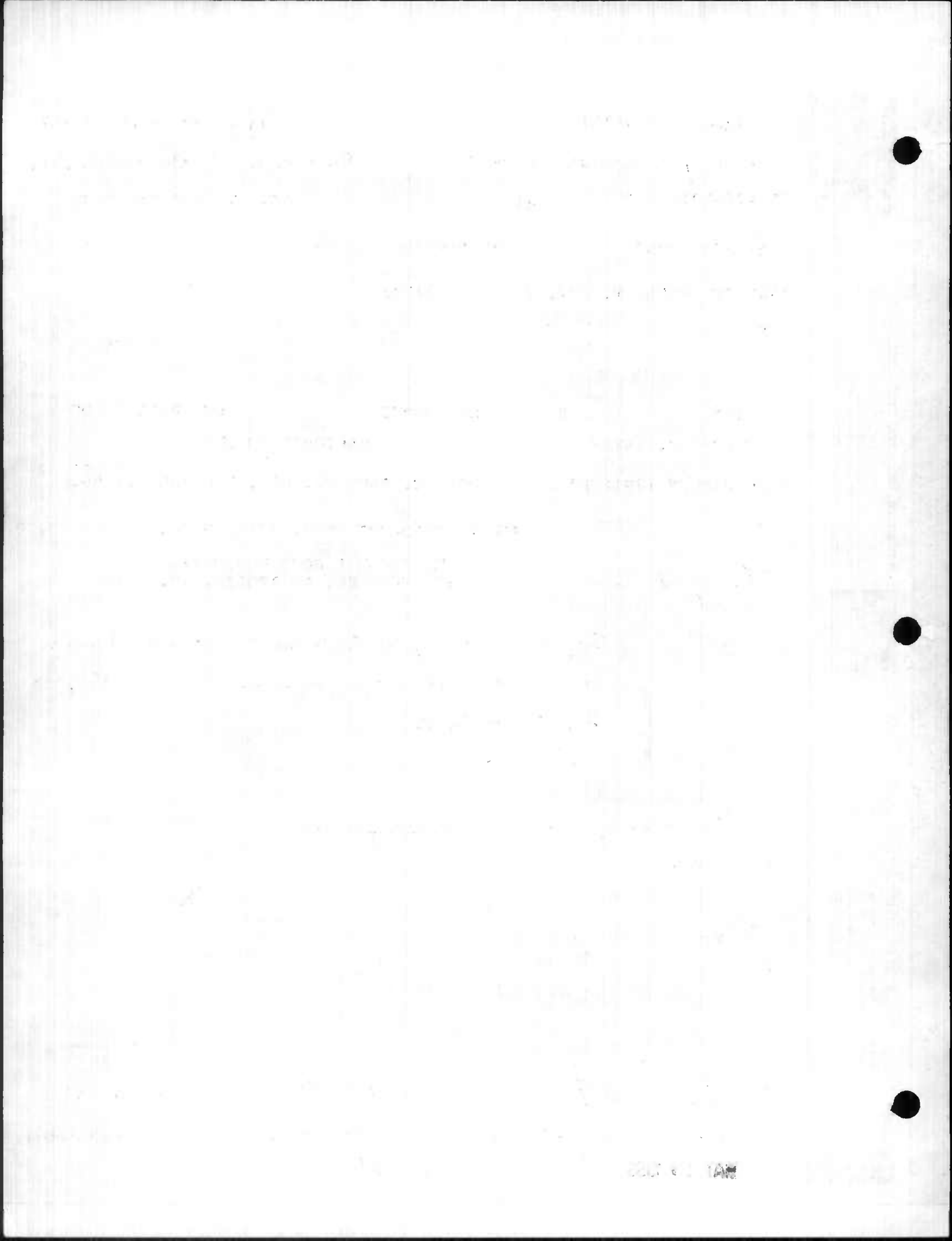
| | | | | | | | | |
|---|---|----------------------------|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HAL GRAHAM | | | | 2. Date of Death
Month Day Year
May 14 1999 | | 3. Time of Death
5 50 | |
| | 4a. Facility Name (If not institution, give street and number)
Mercy Medical Center | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore City | |
| Funeral
Director | 5. Social Security Number
216-76-9019 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
41 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
JUNE 7 1957 | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
NONE | | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
1001 ST. PAUL ST. APT. 2 G | | | | 10f. Zip Code
21202 | | 10g. Citizen of What Country?
US | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify BLACK |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11th College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
FOOD SERVICE | | | 16b. Kind of Business/Industry
US NAVAL ACADEMY | |
| 17. Father's Name (First, Middle, Last)
MELVIN K. HAYES | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MARJORIE COATES | | | |
| 19a. Informant's Name/Relationship (Type, Print)
JOHN HARNEY (FRIEND) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1001 ST. PAUL ST. APT. 2 G BALTO., MD. 21202 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ASBURY BROADNECK CEME. | | | 20c. Location - City or Town, State
5/20/99 ST. MARGARETS, MD. | | |
| 21. Signature of Funeral Service Licensee
<i>Larry S. Reese</i> | | | | | 22. Name and Address of Facility
WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Sepsis secondary to Small Bowel Obstruction
Due to (or as a consequence of):
b. Autoimmune Deficiency Syndrome
Due to (or as a consequence of):
c. Renal failure
Due to (or as a consequence of):
d. pneumonia
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
1 week
10 years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
lymphoma, sarcoma, cytomegalovirus
retinitis | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier
<i>GL BT</i> | | | 29c. License number
UMP 11734 | | 29d. Date signed (Month, Day, Year)
May 14, 1999 |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
GLENN BARQUET 22 S Greene Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 19 1999 | | | 32. Registrar's Signature
<i>Glenn Barquet</i> | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17900

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)
David Pendril GRIFFITH | | | | 2. Date of Death
Month Day Year
May 17, 1999 | | 3. Time of Death
8:15 AM | |
| 4a. Facility Name (If not institution, give street and number)
Cuppett-Weeks Nursing Home | | | | 4b. City, Town, or Location of Death
Oakland | | 4c. County of Death
Garrett | |
| 5. Social Security Number
278-05-1563 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
89 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Aug. 5, 1909 | |
| 9. Birthplace (State or Foreign Country)
Pennsylvania | | | | | | | |
| 10a. State
MD | | 10b. County
Garrett | | 10c. City, Town or Location
Oakland | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number
1746 Stockslager Road | | | | 10f. Zip Code
21550 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+)
4th | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Electrical Engineer | | 16b. Kind of Business/Industry
Electrical Engineering | |
| 17. Father's Name (First, Middle, Last)
Joseph ----- Griffith | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Elsie ----- (Unknown) | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Michele Prichett/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1746 Stockslager Road, Oakland, Maryland 21550 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Laurel Dale Cemetery | | Date
5/21/99 | | 20c. Location - City or Town, State
Reading, Pennsylvania | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Stewart Funeral Home
32 S. Second St., Oakland, MD 21550 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. dehydration
Due to (or as a consequence of): | | | | | Approximate Interval Between Onset and Death
2 weeks |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. dysphagia
Due to (or as a consequence of): | | | | | 3 months |
| | | c. end stage dementia
Due to (or as a consequence of): | | | | | 10 years |
| | | d. | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier

Margaret A. Kaiser | | | | 29c. License number
D26650 | |
| | | 29d. Date signed (Month, Day, Year)
5/17/99 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Margaret Kaiser, MD P.O. Box 486, Oakland, Maryland 21550 | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 19 1999 | | 32. Registrar's Signature
 | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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5

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17901

| | | | | | | | | | | |
|---|--|--|--|--|---|---|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Mary Frances Green | | | | 2. Date of Death
Month Day Year
May 12, 1999 | | | | 3. Time of Death
9:40 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Garrett Memorial Hospital | | | | 4b. City, Town, or Location of Death
Oakland | | | | 4c. County of Death
Garrett | |
| Funeral
Director | 5. Social Security Number
215-16-4408 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
76 Yrs. | | 8. Date of Birth (Month, Day, Year)
Jan. 14, 1923 | | 9. Birthplace (State or Foreign Country)
MD | |
| | Usual Residence of Decedent | | | | 10a. State
MD | | 10b. County
Garrett | | 10c. City, Town or Location
Barton | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
7752 Westernport Rd. | | 10f. Zip Code
21521 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Unknown College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | | 16b. Kind of Business/Industry
Home | | |
| 17. Father's Name (First, Middle, Last)
John E. Clark | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Ethel Fazenbaker | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Jesse Green / Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7752 Westernport Rd. Barton, MD 21521 | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mountain View Cemetery | | Date
5/15/99 | | 20c. Location - City or Town, State
Moscow Mills, MD | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Boal Funeral Home
111 Church St. Westernport, MD 21562 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Anoxic brain damage following resuscitation
Due to (or as a consequence of): for ventricular fibrillation

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
5 days
Due to (or as a consequence of):
Due to (or as a consequence of):
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Coronary artery disease, diabetes, Type II controlled
Hypertension, chronic renal failure, congestive heart failure | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner | | 29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
D26650 | | 29d. Date signed (Month, Day, Year)
5/12/99 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Margaret A. Kaiser MD PO Box 486 Oakland, MD 21550 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 13 1999 | | 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17902

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | | | |
|---|--|---|--|--|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)
PAULINE ANN GLOTFELTY | | | | | | 2. Date of Death
Month Day Year
MAY 7, 1999 | | 3. Time of Death
4:15 A.M. | |
| 4a. Facility Name (If not institution, give street and number)
5621 WESTGATE ROAD | | | | 4b. City, Town, or Location of Death
LANHAM | | 4c. County of Death
PRINCE GEORGE'S | | | |
| 5. Social Security Number
578-50-0365 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
61 Yrs. | | 8. Date of Birth (Month, Day, Year)
JULY 23, 1937 | | 9. Birthplace (State or Foreign Country)
VIRGINIA | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
PRINCE GEORGE'S | | 10c. City, Town or Location
LANHAM | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
5621 WESTGATE ROAD | | | | 10f. Zip Code
20706 | | 10g. Citizen of What Country?
UNITED STATES | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
BOOKKEEPER | | | 16b. Kind of Business/Industry
ACCOUNTING | | |
| 17. Father's Name (First, Middle, Last)
ELLSWORTH E. IMLAY | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
PAULINE B. LANGFORD | | | |
| 19a. Informant's Name/Relationship (Type, Print)
PAULA J. PERRY, COUSIN | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5704 30TH AVENUE, HYATTSVILLE, MARYLAND 20782 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
FORT LINCOLN CEMETERY | | Date
5/11/99 | | 20c. Location - City or Town, State
BRENTWOOD, MARYLAND | | | |
| 21. Signature of Funeral Service Licensee
<i>Louis L. Grant</i> | | | | 22. Name and Address of Facility
FORT LINCOLN FUNERAL HOME
3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. WIDESPREAD ADENOCARCINOMA
Due to (or as a consequence of):
b. METASTASIS TO BRAIN
Due to (or as a consequence of):
c. CANCER OF LUNG
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| 24e. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC OBSTRUCTIVE LUNG DISEASE | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
2 <input checked="" type="checkbox"/> Medical Examiner | | 29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier
<i>James W. Harding MD</i> | | 29c. License number
D05401 | | | | 29d. Date signed (Month, Day, Year)
<i>May 13, 1999</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JAMES W. HARDING, M.D., 7525 GREENWAY CENTER DR., #316, GREENBELT, MD 20770 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1999 | | 32. Registrar's Signature
<i>B. Smith</i> | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

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99-2908-031

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
 WILLIAM AMEN: #23 PART I PER MEO G773 7-13-99 WR. WR. 99 17903
 GRIFFIN SR. ITEMS: #23 PART I, 27 PER MEO G772 6-1-99 Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|---|--|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
William Arthur Griffin | | | | 2. Date of Death
Month Day Year
MAY 19, 1999 | | 3. Time of Death
3:05P.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
7922 CORIANDER DRIVE | | | | 4b. City, Town, or Location of Death
GAITHERSBURG | | 4c. County of Death
MONTGOMERY | | |
| Funeral
Director | 5. Social Security Number
243-88-9066 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
43 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 4, 1955 | | |
| | 9. Birthplace (State or Foreign Country)
Fort Bragg, NC | | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Gaithersburg | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
7922 Coriander Drive #302 | | 10f. Zip Code
20879 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+)
3 YRS. | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Service Provider | | 16b. Kind of Business/Industry
FED. EX.- PVT. IND. | | | | | |
| 17. Father's Name (First, Middle, Last)
JAMES ARTHUR LEE GRIFFIN | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MAGGIE MOORE | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
CHERYL GRIFFIN-CARRINGTON/ SISTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
407 Northumberland St. Fayetteville, NC 28314 | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | Date
5-25-99 | | 20c. Location - City or Town, State
Alexandria, Virginia | | | |
| 21. Signature of Funeral Service Licensee
<i>Shawanda Braxton</i> | | | | 22. Name and Address of Facility
Marshall's Funeral Home of MD
4308 Suitland Rd. Suitland, Maryland 20746 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. <u>FATTY LIVER</u>
Due to (or as a consequence of):

b. <u>CHRONIC ALCOHOLISM</u>
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Dennis J. Chute</i> | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 20, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Dennis J. Chute, MD</i> | | 31. Date filed (Month, Day, Year)
MAY 27 1999 | | 32. Registrar's Signature
<i>B. Spats</i> | | 111 Penn Street, Baltimore, Maryland 21201 | | | |

MAV 3 1959

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17904

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARTHA GODBOLDTE

2. Date of Death

Month

Day

Year

MAY

15,

1999

3. Time of Death

11:25 PM

4a. Facility Name (If not institution, give street and number)

BERLIN NURSING AND REHAB. CENTER

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral
Director

5. Social Security Number

266-26-4291

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

November 16, 1920

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Worcester

10c. City, Town or Location

Ocean City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

7604 Costal Hwy Unit 4C

10f. Zip Code

21842

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

lyr.

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

House Wife

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Alonzo Burke

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Glascoe

19a. Informant's Name/Relationship (Type, Print)

Jacqueline Richards/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7604 Costal Hwy Unit 4C, Ocean City, Maryland 21842

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Cemetery

Date

05/20

1999

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perenti

22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC LUNG CANCER

Due to (or as a consequence of):

b. HEAD & NECK CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Nancy A. Perenti

29c. License number

D46257

29d. Date signed (Month, Day, Year)

J/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9715 Heathway Drive P.O. Box 799 Berlin, MD 21811

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

B. Smith

State
Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

GODBOLDTE, MARTHA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17905

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FRANK A. GUARAGNA

2. Date of Death

May

16

1999

3. Time of Death

10:15 PM

4a. Facility Name (If not institution, give street and number)

10416 Cleary Lane

4b. City, Town, or Location of Death

Mitchellville

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

577-32-5065

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

April 15, 1928

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Md.

10b. County

Prince Georges

10c. City, Town or Location

Mitchellville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10416 CLEARY LANE

10f. Zip Code

20721

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 46-48

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Printing Officer

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Alfredo Guaragna

18. Mother's Name (First, Middle, Maiden Surname)

Carmela Barbagallo

19a. Informant's Name/Relationship (Type, Print)

Sally Guaragna/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as 10e

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lakemont Memorial Gardens May 20, 1999 Davidsonville, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Robert E. Evans Funeral Home Inc 16000 Annapolis Rd., Bowie, Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. *terminal cancer of colon*
Due to (or as a consequence of):b. *Liver metastasis*
Due to (or as a consequence of):c. *Coagulopathy*
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
Investigation6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D13339

29d. Date signed (Month, Day, Year)

5/17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tshai E. Chanhiem 882K Cunningham Dr. Berwyn, Md.

31. Date filed (Month, Day, Year)

MAY 18 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99-17906

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Michael Boris Gavrisheff | | | | 2. Date of Death
Month May Day 18 Year 1999 | | 3. Time of Death
06:10 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Holy Cross Hospital | | | | 4b. City, Town, or Location of Death
Silver Spring | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
466-10-4312 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
81 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Oct. 17, 1917 | 9. Birthplace (State or Foreign Country)
Russia |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Md | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
11706 College View Drive Silver Spring 20902 | | | | 10f. Zip Code | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1940-1962 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Self Employed-Owner | | | 16b. Kind of Business/Industry
Desk Top Publishing | |
| 17. Father's Name (First, Middle, Last)
Boris Ivan Gavrisheff | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Olga Vbyshevsky | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Alexis Gavrisheff/son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4010 Potosi Rd. Pensicola, Florida 32504 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rock Creek Cemetery 5/20/99 Wash.D.C. | | | 20c. Location - City or Town, State | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
PHILIP D. RINALDI FUNERAL SERVICE
11818 New Hampshire Ave. Silver Spg, Md | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. LUNG CANCER
Due to (or as a consequence of):
b. Pulmonary Embolism
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
1 month |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24e. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>[Signature]</i> | | | 29c. License number
D2675 | | 29d. Date signed (Month, Day, Year)
MAY 18 1999 | |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)
Hector K. Collison MD 8401 Colesville Rd Silver Spring MD 20910 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 19 1999 | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

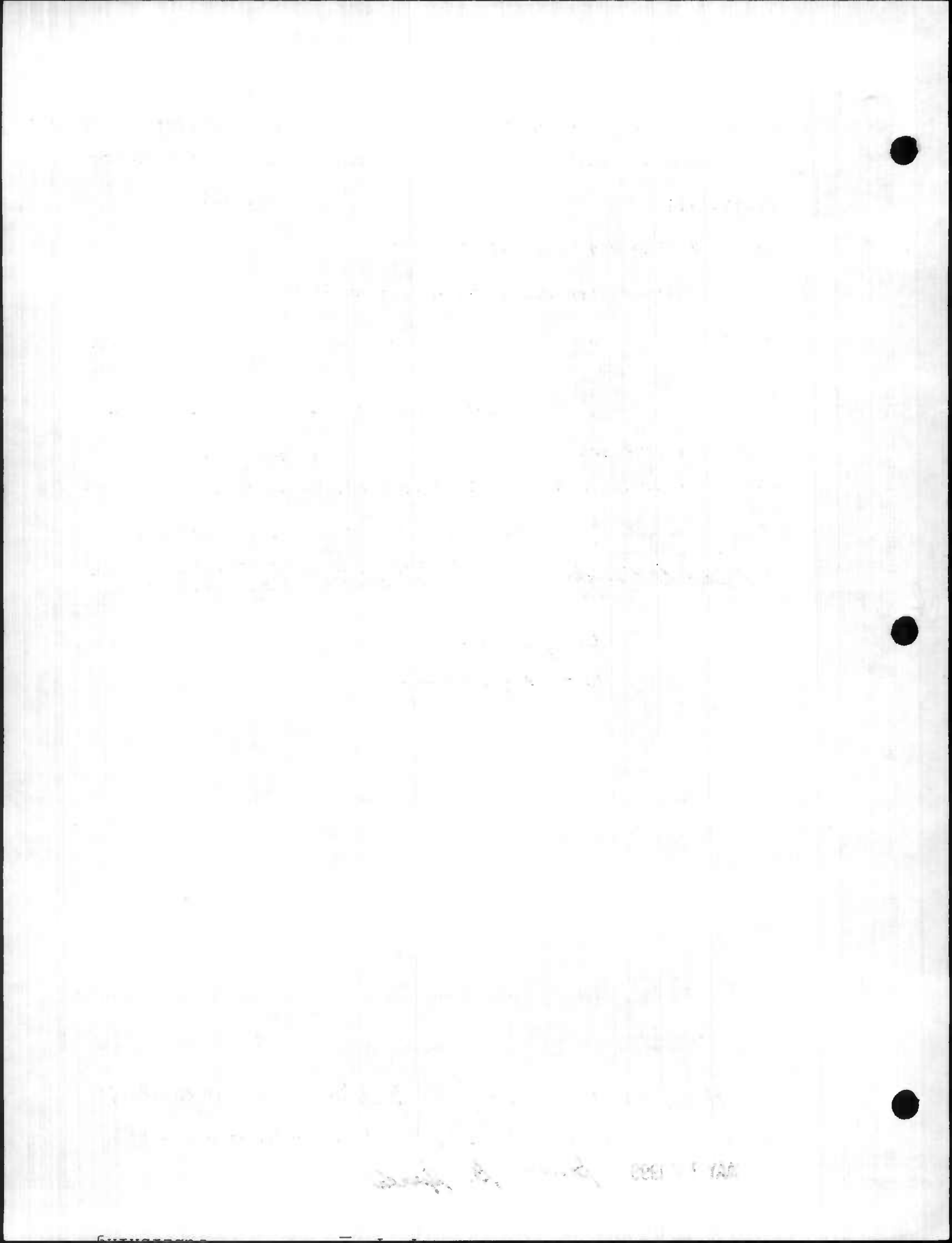
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17907

| | | | | | | | | |
|---|---|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
KALVIN GILBERT | | | | 2. Date of Death
Month Day Year
MAY 19, 1999 | | 3. Time of Death
0233 AM | |
| | 4a. Facility Name (If not institution, give street and number)
PRINCE GEORGES HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
CHEVERLY | | 4c. County of Death
PRINCE GEORGES | |
| Funeral
Director | 5. Social Security Number
577-88-7586 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
31 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 22, 1967 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Landover | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
7126 East Cedar Street | | 10f. Zip Code
20785 | | |
| 10g. Citizen of What Country?
U.S.A. | | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laborer | | 16b. Kind of Business/Industry
Private | | |
| 17. Father's Name (First, Middle, Last)
Tom Gilbert | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Martha Jones | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Martha Ann Green/Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1907 Belle Haven Drive, Landover, Maryland 20785 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Memorial Park Cemetery | | Date
05/25 1999 | | 20c. Location - City or Town, State
Landover, Maryland | | |
| 21. Signature of Funeral Service Licensee
<i>Behna J. Jenkins</i> | | | | 22. Name and Address of Facility
J.B. JENKINS FUNERAL HOME
7474 Landover Road, Landover, Maryland 20785 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Head and neck injuries
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. _____
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d. _____ | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
5-19-99 | | 28b. Time of Injury
0155 M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred
Automobile accident | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
6000 Columbia Pike
Prince Georges County, Maryland | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Stephen S. Radentz</i> | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 20, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 21 1999 | | | | 32. Registrar's Signature
<i>James A. Smith</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Handwritten signature 6201 F 5 YAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17208

| | | | | | | | | |
|---|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Richard Michael Gleason | | | | 2. Date of Death
Month Day Year
MAY 13, 1999 | | 3. Time of Death
1245 PM | |
| | 4a. Facility Name (If not institution, give street and number)
2336 IRONWOOD DRIVE | | | | 4b. City, Town, or Location of Death
WALDORF | | 4c. County of Death
CHARLES | |
| Funeral
Director | 5. Social Security Number
214-62-8126 | | 6. Sex
1 <input type="checkbox"/> M 2 <input type="checkbox"/> F
X | | 7. Age (In yrs. last birthday)
43 Yrs. | | 8. Date of Birth (Month, Day, Year)
11/6/55 | |
| | 9. Birthplace (State or Foreign Country)
Colorado | | 10a. State
Maryland | | 10b. County
Charles | | 10c. City, Town or Location
Waldorf | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
2336 Ironwood Dr. | | 10f. Zip Code
20601 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Printer | | 16b. Kind of Business/Industry
Bureau of Engraving | | 17. Father's Name (First, Middle, Last)
James Joseph Gleason | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Rosemary Merrill | | 19a. Informant's Name/Relationship (Type, Print)
Rosemary E. Gleason/Mother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11450 Asbury Circle Apt. 117 Solomons, MD. 20688 | | 20e. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resurrection Cemetery | | 20c. Location - City or Town, State
Clinton, Maryland | | 21. Signature of Funeral Service Licensee
George P. Kalas | | 22. Name and Address of Facility
George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 20745 | |
| | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. CARBON MONOXIDE INTOXICATION
Due to (or as a consequence of): | | 23b. Part II: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | 23c. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Were an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year)
JUN 5-13-99 | | 28b. Time of Injury
1230 P M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
CAR TURNED EXHAUST FUMES FROM CAR | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of injury - At home, farm, street, tectory, office building, etc. (Specify)
GARAGE - IN A CAR | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
2336 IRONWOOD DR. CHARLES CO MD | | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Wayne D. Bell MD | |
| | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 14, 1999 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wayne D. Bell 111 Penn Street, Baltimore, Maryland 21201 | | 31. Date filed (Month, Day, Year)
MAY 17 1999 | |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature
B. Jones | | 33. Registrar's Signature
B. Jones | | 34. Registrar's Signature
B. Jones | | 35. Registrar's Signature
B. Jones | |
| | 36. Registrar's Signature
B. Jones | | 37. Registrar's Signature
B. Jones | | 38. Registrar's Signature
B. Jones | | 39. Registrar's Signature
B. Jones | |

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QED C J YAI

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 17909

ITEM#20b&20c PER F.H. G772 6-3-99 J.A.

Certificate of Death

Reg. No.

| | | | | | |
|---|---|---|---|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
THANG ELLIOT HARRIS | | 2. Date of Death
Month Day Year
MAY 8 1999 | | 3. Time of Death
10:18pm |
| | 4a. Facility Name (If not institution, give street and number)
GREATER BALTIMORE MEDICAL CENTER | | 4b. City, Town, or Location of Death
TOWSON | | 4c. County of Death
BALTIMORE |
| Funeral
Director | 5. Social Security Number
N/A | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
Yrs. Months Days | 8. Date of Birth (Month, Day, Year)
1 46 5/8/99 | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | 10b. County
N/A | 10c. City, Town or Location
N/A | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
2406 MOLTON WAY | | 10f. Zip Code
21244 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: UNKNOWN |
| | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) NONE Collage (1-4or 5+) NONE | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
NONE | | 16b. Kind of Business/Industry
NONE | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
THANG NONG | | 18. Mother's Name (First, Middle, Maiden Summa)
TIA NICHOLE HARRIS | | |
| | 19a. Informant's Name/Relationship (Type, Print)
G.B.M.L. PATHOLOGY | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6701 N. CHARLES ST. TOWSON, MD. 21204 | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GREENMOUNT CREMATORY | | 20c. Location - City or Town, State
5/13/99 BALTO. CITY, MD. |
| | 21. Signature of Funeral Service Licensee
William R. Smith | | 22. Name and Address of Facility
HENRY W. JENKINS & SONS CO.
4905 YORK RD. BALTO. MD. 21212 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. EXTREME PREMATUREITY
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
2 hours | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accidental 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
[Signature] | | 29c. License number
D0052591 | | 29d. Date signed (Month, Day, Year)
5/8/99 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
KATHLEEN RYAN 218 N. CHARLES #300, BALTIMORE, MARYLAND | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 8 1999 | | 32. Registrar's Signature
[Signature] | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 17910

AMEND# 20B, 24A AACO HEALTH CMH 5/18/99

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|--|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Kenneth F. Hachey | | | | 2. Date of Death
Month Day Year
May 14, 1999 | | 3. Time of Death
6:05 PM | |
| | 4a. Facility Name (If not institution, give street and number)
915 Boom Way | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
059-26-6353 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
66 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Oct. 4, 1932 | 9. Birthplace (State or Foreign Country)
Canada |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Annapolis | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
915 Boom Way | | | | 10f. Zip Code
21401 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1952-54 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 yrs. Collega (1-4or 5+) 2 yrs. | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Insurance Agent | | 16b. Kind of Business/Industry
Insurance | | |
| 17. Father's Name (First, Middle, Last)
Nicholas Hachey | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Marie Chouinard | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Valerie V. Hachey/ Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
915 Boom Way Annapolis, Maryland 21401 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery | | Data
5-18-99 | | 20c. Location - City or Town, State
Ossining, New York | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
George P. Kalas Funeral Home
2973 Solomons Island Rd. Edgewater, MD 21037 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Cancer of Lung
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death
9 mo |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and Title of Certifier
 | | 29c. License number
008118 | | 29d. Date signed (Month, Day, Year)
5/15/99 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Stanley Watkins, M.D. 900 Bestgate Rd. Annapolis, Maryland 21401 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 18 1999 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

MAY 18 1953

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17911

| | | | | | | | | | | |
|---|---|-----------------------------|---|---|--|--|--|--|-----------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ruth Duke Hunt | | | | 2. Date of Death
Month Day Year
May 15 1999 | | 3. Time of Death
6:00 AM | | | |
| | 4a. Facility Name (If not institution, give street and number)
181 Defense Highway | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | | | |
| Funeral
Director | 5. Social Security Number
214-05-1273 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)
86 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
May 12, 1913 | 9. Birthplace (State or Foreign Country)
North Carolina | | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Md. | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Annapolis | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
181 Defense Highway | | | | 10f. Zip Code
21401 | | 10g. Citizen of What Country?
USA | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Collage (1-4or 5+)
2 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Nurse | | | 16b. Kind of Business/Industry
Hospital | | | | |
| 17. Father's Name (First, Middle, Last)
Jordan P. Duke | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Rachael V. McLennan | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Harold L. Hunt / husband | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
181 Defense Highway Annapolis, MD 21401 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Cemetery | | Data
5-18-99 | | 20c. Location - City or Town, State
Annapolis, MD | | | |
| 21. Signature of Funeral Service Licensee
C. Brian Powell | | | | | 22. Name and Address of Facility
John M. Taylor Funeral Home, Inc.
147 Duke of Gloucester St. Annapolis, MD 21401 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Pneumonia
Due to (or as a consequence of):
b. Bipolar Disorder
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | | Approximate Interval Between Onset and Death
one week
Many years | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier
S. Killian | | | 29c. License number
D29193 | | 29d. Date signed (Month, Day, Year)
05/17/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen Killian, M.D. 180 Admiral Cochrane Dr. Annapolis, Md. 21401 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 18 1999 | | | Registrar's Signature
S. Killian | | | | | | | |

To Be Completed by Funeral Director

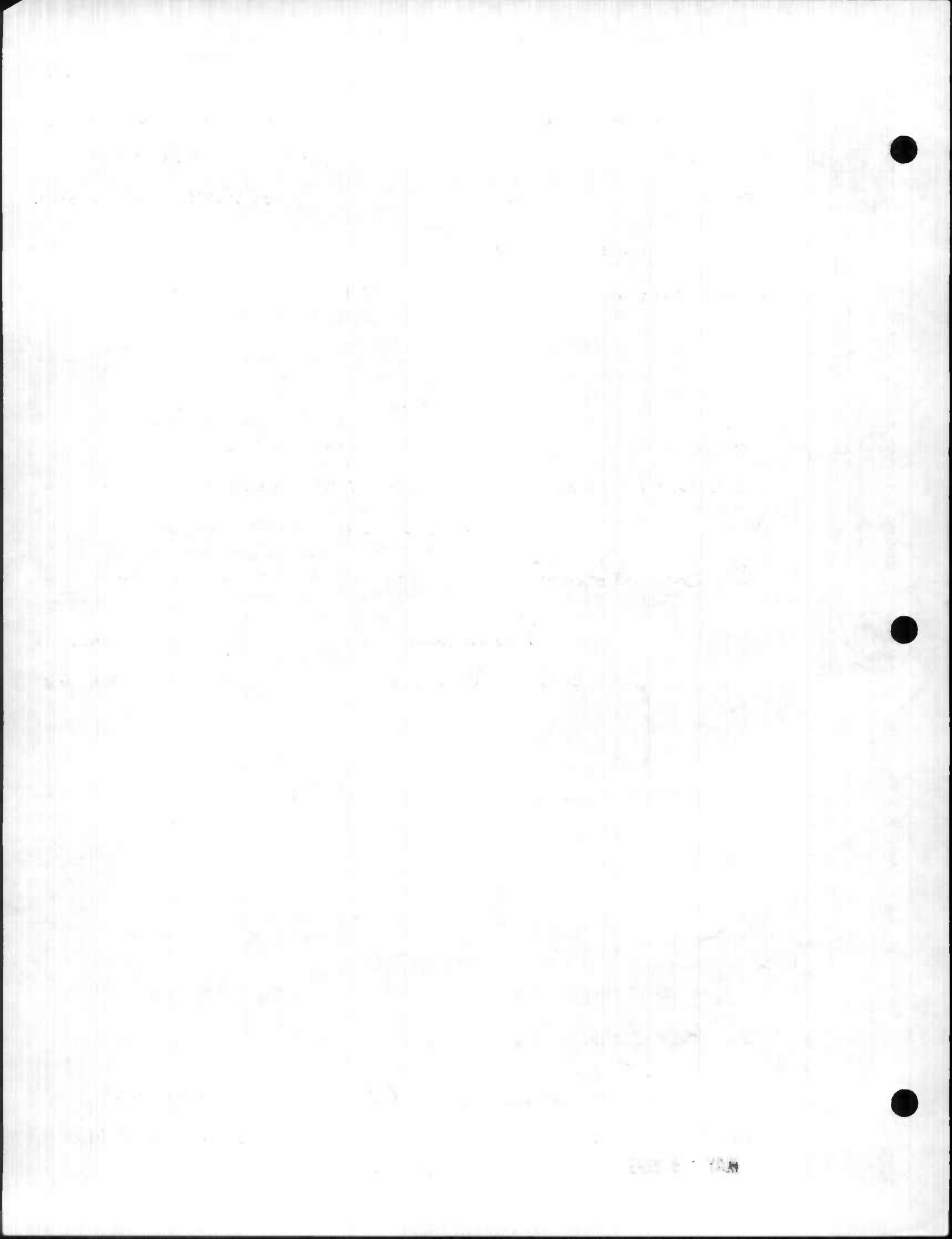
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17912

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHNNIE MAE HODGE

2. Date of Death

Month
MayDay
15Year
1999

3. Time of Death

6:00 A.M.

4a. Facility Name (If not institution, give street and number)

MARINER HEALTH OF BETHESDA

4b. City, Town, or Location of Death

Northern Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-24-1383

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 25, 1915

9. Birthplace (State or Foreign Country)

Moultrie, GA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Northern Bethesda

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5721 Grosvenor Lane

10f. Zip Code

20814

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☒ Yes ☐ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

John Davis

18. Mother's Name (First, Middle, Maiden Surname)

Jessie Merritt

19a. Informant's Name/Relationship (Type, Print)

Henry J. Davis/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1628 Front Street Scotch Plains, N.J. 07076

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Northern Virginia Crematory


Date

5/15/99

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Frazier's Funeral Home, Inc.
389 R.I. Ave., N.W. Wash., DC 20001

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Alzheimers Dementia, End Stage

Due to (or as a consequence of):

years

b. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. _____
Due to (or as a consequence of):d. _____
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D28135

29d. Date signed (Month, Day, Year)

May 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

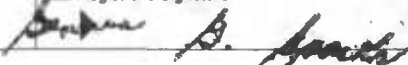
Donna Rinis, MD

6000 Executive Blvd. Suite 300 Rockville, Md. 20852

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 17913

ITEM: #1 PER MD G772 6-15-99 WR.

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|---|--|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
VIRGIL HOFFMAN VIRGIL HOFFMANN | | | | | | 2. Date of Death
Month Day Year
MAY 17, 1999 | | 3. Time of Death
0835 am | |
| | 4a. Facility Name (If not institution, give street and number)
CALVERT MEMORIAL HOSPITAL | | | | | | 4b. City, Town, or Location of Death
Prince Frederick | | 4c. County of Death
Calvert | |
| Funeral
Director | 5. Social Security Number
579-66-9951 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
89 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 5, 1909 | | 9. Birthplace (State or Foreign Country)
Washington, D.C. | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10e. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Edgewater | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
1208 Bayview Court | | | | | | 10f. Zip Code
21037 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4or 5+) College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Private | | | |
| 17. Father's Name (First, Middle, Last)
James Ellsworth Harding | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Gertrude Goddard | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Diana L. Burke/ Granddaughter | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
204 Linden Ave., Edgewater, MD 21037 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery | | Date
5/20/99 | | 20c. Location - City or Town, State
Suitland, MD | | |
| 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
Cedar Hill Funeral Home, Inc.
4111 Pennsylvania Ave., Suitland, MD 20746 | | | | |
| 23a. Part I. Enter one disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Renal Failure
Due to (or as a consequence of):

b. DEHYDRATION
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Atrial Fibrillation | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | | 29c. License number
D-25435 | | 29d. Date signed (Month, Day, Year)
5/18/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. M. Mathur, M.D. 110 Hospital Drive, Suite 305 Prince Frederick, MD 20678 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 19 1999 | | 32. Registrar's Signature
 | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Georgia Hart

2. Date of Death

Month Day Year
May 14 1999

3. Time of Death

1053 AM

4a. Facility Name (If not institution, give street and number)

Prince Georges Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince Georges

5. Social Security Number

578-52-7671

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
January 11, 1939

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Seat Pleasant

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

303 68th Place

10f. Zip Code

20743

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th

Collega (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

House Keeper

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Bennie White

18. Mother's Name (First, Middle, Maiden Surname)

Ollie Williams

19a. Informant's Name/Relationship (Type, Print)

Joe Freddie Hart/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

303 68th Place, Seat Pleasant, Maryland 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park Cemetery

Date

05/19 1999

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Massive intracerebral hemorrhage

Due to (or as a consequence of):

b. cerebral infarct

Due to (or as a consequence of):

c. coagulopathy

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ventricular fibrillation

anoxic encephalopathy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

D51006

29d. Date signed (Month, Day, Year)

May 15th, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J.D. Allyn, M.D. 3001 Hospital Drive Cheverly MD 20785

31. Date filed (Month, Day, Year)

MAY 18 1999

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

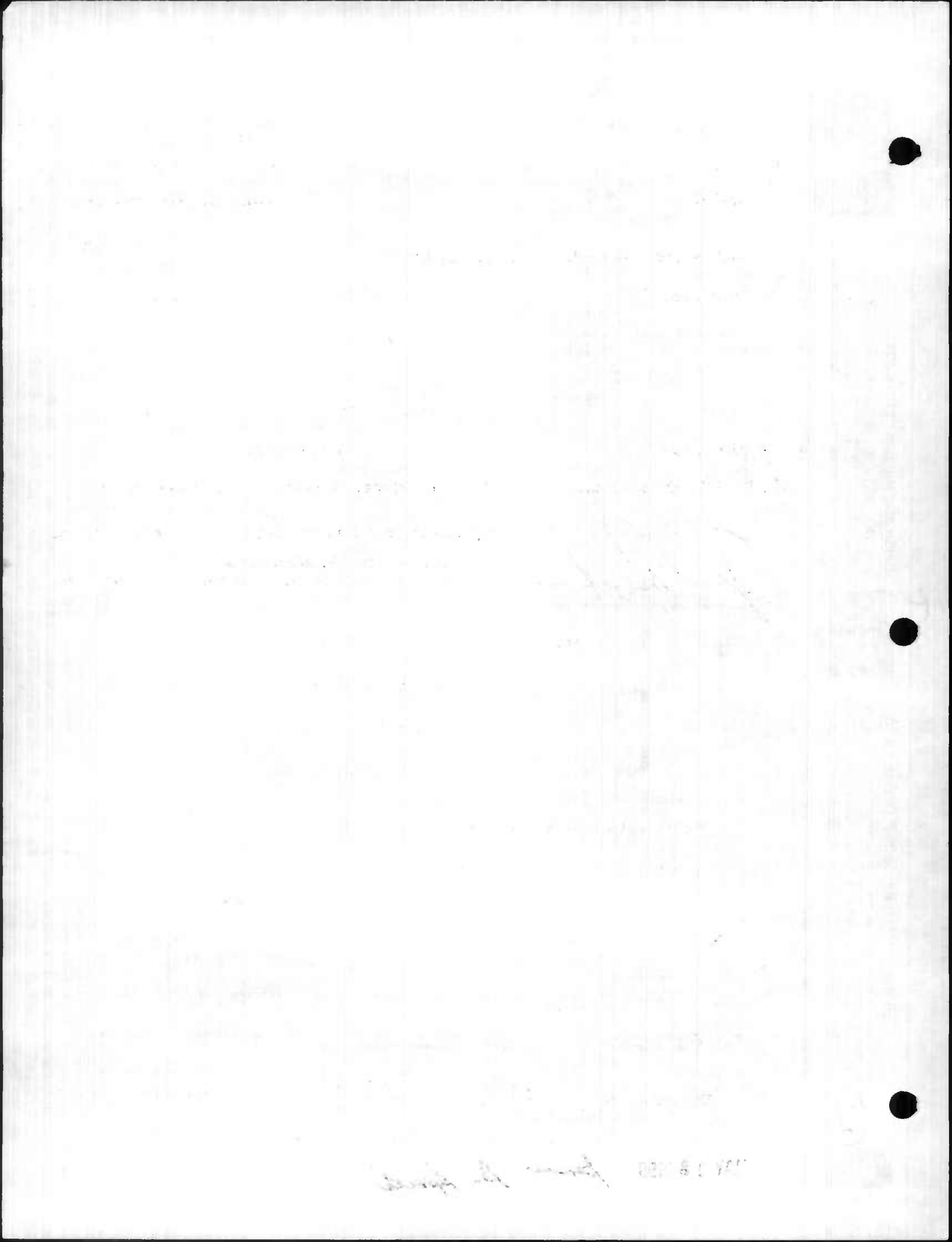
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17915

| | | | | | | | | |
|---|--|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
FREDDIE HAMILTON | | | | 2. Date of Death
Month MAY Day 16 Year 1999 | | 3. Time of Death
9:30PM | |
| | 4a. Facility Name (If not institution, give street and number)
3708 Endicott Place | | | | 4b. City, Town, or Location of Death
Springdale | | 4c. County of Death
Prince Georges | |
| Funeral
Director | 5. Social Security Number
577-05-7386 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
83 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
4-5-16 | 9. Birthplace (State or Foreign Country)
Edgefield, SC |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD. | | 10b. County
Prince Georges | | 10c. City, Town or Location
Springdale | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
3708 Endicott Place | | | | 10f. Zip Code
20774 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laborer | | | 16b. Kind of Business/Industry
N/A | |
| 17. Father's Name (First, Middle, Last)
Henry Hamilton | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Alice Doggett | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Tanya Smith/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3708- Endicott Place, Springdale, Md. 20774 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glenwood Cemetery | | Date
5/21/99 | | 20c. Location - City or Town, State
Washington, D.C. |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Hackett's Funeral Chapel, Inc.
814- Upshur Street, N.W. | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Cerebro Vascular Accident

Due to (or as a consequence of):
Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
1 week

20 years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D38322 | | 29d. Date signed (Month, Day, Year)
May 17, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gregory Johnson, M.D. 7525- Greenway Center Dr., S-213 Greenbelt, Md. 20770 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 18 1999 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17916

| | | | | | | | | |
|--|---|--|---|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Paul T. Hobgood, Sr. | | | | 2. Date of Death
Month Day Year
May 14, 1999 | | 3. Time of Death
3:29 A. M. | |
| | 4a. Facility Name (If not institution, give street and number)
Southern Maryland Hospital Center | | | | 4b. City, Town, or Location of Death
Clinton | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
232-30-4740 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
74 Yrs. | 8. Date of Birth (Month, Day, Year)
Dec. 5, 1924 | 9. Birthplace (State or Foreign Country)
North Carolina | | |
| | Usual Residence of Decedent | | | | 8. Date of Birth (Month, Day, Year) | | 9. Birthplace (State or Foreign Country) | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Oxon Hill | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
5507 Helmont Drive | | | | 10f. Zip Code
20745 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1945-48 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Bus Driver | | 16b. Kind of Business/Industry
Transportation | |
| | 17. Father's Name (First, Middle, Last)
George W. Hobgood | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Nancy Hobgood | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mary A. Hobgood/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5507 Helmont Dr. Oxon Hill, MD 20745 | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Roselawn Cemetery | | Date
5/18/99 | | 20c. Location - City or Town, State
Benson, N. Carolina | |
| | 21. Signature of Funeral Service Licensee
<i>George P. Kalas</i> | | | | 22. Name and Address of Facility
George P. Kalas Funeral Home, P.A.
6160 Oxon Hill Rd. Oxon Hill, MD 20745 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>Renal failure</i>
Due to (or as a consequence of):
<i>Sepsis</i>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
<i>Arterio femoral Graft Infection</i>
Due to (or as a consequence of):
<i>Compromised leg</i> | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | | | 29c. License number
DL4644 | | 29d. Date signed (Month, Day, Year)
5/14/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GARY S GROVER, MD 7501 SULLY RD #303 CLINTON MD 20735 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1999 | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

15

State
Registrar

[Faint, illegible text covering the majority of the page, possibly bleed-through from the reverse side.]

[Handwritten signature or initials.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Thompson Bruce Hawkins-El

2. Date of Death

Month Day Year
May 11, 1999

3. Time of Death

12:55 P.M.

4a. Facility Name (If not institution, give street and number)

Fort Washington Hospital

4b. City, Town, or Location of Death

Fort Washington

4c. County of Death

Prince Georges

5. Social Security Number

579-64-6436

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 1950

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Temple Hills

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3855 - 28th Avenue

10f. Zip Code

20748

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 years

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Trucking Company

17. Father's Name (First, Middle, Last)

Francis Alexander Hawkins

18. Mother's Name (First, Middle, Maiden Surname)

Irene Thompson

19a. Informant's Name/Relationship (Type, Print)

(wife)

Diane Thomasina Dickerson Hawkins-El

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3855 - 28th Avenue, Temple Hills, Maryland

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)May 18, 1999
National Harmony Memorial Park

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

► *Leander M. Coles*

22. Name and Address of Facility

Robert G. Mason Funeral Home, Inc.
1661 Good Hope Road, S.E.; Washington, D.C. 2002023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. **Cardiopulmonary Arrest**

Due to (or as a consequence of):

b. **Hepatic Failure**

Due to (or as a consequence of):

c. **Severe Cholangitis**

Due to (or as a consequence of):

d. **Metastatic Carcinoma of Pancreas**Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Hypertension

Obstructive Jaundice

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was cause related to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

► *[Signature]*

29c. License number

D24523

29d. Date signed (Month, Day, Year)

May 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Obiora M. Ogbuawa, M.D.; 11701 Livingston Road, Suite 209; Fort Washington, Maryland

20744

31. Date filed (Month, Day, Year)

MAY 17 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1991-1992

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17918

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GLORIA JEAN

HUBBARD

2. Date of Death

MAY 12 1999

3. Time of Death

11:50 a.m.

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

577 66 8061

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

FEB. 3, 1951

9. Birthplace (State or Foreign Country)

WASHINGTON, DC

Usual Residence of Decedent

10a. State

N/A

10b. County

N/A

10c. City, Town or Location

WASHINGTON, DC

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

533 NEWTON PL., NE

10f. Zip Code

20010

10g. Citizen of What Country?

UNITED STATES OF AMERICA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH

College (1-4 or 5+)

NONE

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

SCHOOL ADMINISTRATOR

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

DANIEL FORTUNE

18. Mother's Name (First, Middle, Maiden Surname)

ROSA VIRGINIA HARRIS

19a. Informant's Name/Relationship (Type, Print)

WILLIAM F. HUBBARD HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

533 NEWTON PL., NE WASHINGTON, DC 20010

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FT. LINCOLN CEMETERY

Date

5/17/99

20c. Location - City or Town, State

BRENTWOOD, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOHN T. RHINES COMPANY, INC.
3030 12TH ST., NE WASHINGTON, DC 20017

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

20 YRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. BONE MARROW TRANSPLANT

Due to (or as a consequence of):

30 DAYS

c. MULTIPLE MYELOMA

Due to (or as a consequence of):

2 YEARS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide4 ☐ Homicide4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0063335

29d. Date signed (Month, Day, Year)

MAY 12, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

WILLIAM MATSUI, MD 600 NORTH WALKER STREET BALTIMORE, MD 21287

31. Date filed (Month, Day, Year)

MAY 17 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17919

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
Rachel C. Holley | | | | 2. Date of Death
Month Day Year
May 22, 1999 | | 3. Time of Death
4: 16 pm | |
| 4a. Facility Name (If not institution, give street and number)
Southern Maryland Hospital | | | | 4b. City, Town, or Location of Death
Clinton | | 4c. County of Death
Prince Georges | |
| 5. Social Security Number
218-20-1438 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
89 Yrs. | | 8. Date of Birth (Month, Day, Year)
December 15, 09 Maryland | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Prince Georges | | 10c. City, Town or Location
Upper Marlboro | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number
8701 Bing Hampton Place | | | | 10f. Zip Code
20772 | | 10g. Citizen of What Country?
U.S.A | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify:
Black | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Domestic | |
| 17. Father's Name (First, Middle, Last)
Charles DeVille | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Annie Bell DeVille | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Veronica C. Jones/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8701 Bing Hampton Pl. Upper Marlboro MD 20772 | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resurrection | | Data
May 28, 99 | | 20c. Location - City or Town, State
Clinton, MD | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
ADAMS FUNERAL HOME P.A., AQUASCO MD 20608 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC ARREST
Due to (or as a consequence of):
b. ARTERIOSCLEROTIC HEART DISEASE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d. | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D12906 | | 29d. Date signed (Month, Day, Year)
5/25/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Louis Kaufman 8926 Woodlyn Road #602 Clinton, MD 20735 | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 25 1999 | | | | 32. Registrar's Signature
 | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 17920

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|---|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Basil Guy Hill | | | | 2. Date of Death
Month Day Year
May 8, 1999 | | 3. Time of Death
7:50 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
28455 Locks Hill Road | | | | 4b. City, Town, or Location of Death
Mechanicsville | | 4c. County of Death
St. Mary's | | |
| Funeral
Director | 5. Social Security Number
220-28-6218 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
68 Yrs. | 8. Date of Birth (Month, Day, Year)
June 25, 1930 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
Maryland | | 10b. County
St. Mary's | | 10c. City, Town or Location
Mechanicsville | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
28455 Locks Hill Road | | | | 10f. Zip Code
20659 | | 10g. Citizen of What Country?
U.S.A. | | | |
| 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4or 5+) | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Welder | | | 16b. Kind of Business/Industry
Metal Fabrication | | |
| 17. Father's Name (First, Middle, Last)
Francis Guy Hill | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Myrtle L. Thompson | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
James Walter Hill/Brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
28455 Locks Hill Road, Mechanicsville, MD 20659 | | | | | |
| 20e. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Catholic Cemetery | | Date
5/11/99 | | 20c. Location - City or Town, State
Bryantown, MD | | | |
| 21. Signature of Funeral Service Licensee
<i>James P. Jarboe</i> | | | | 22. Name and Address of Facility
Matteringley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, MD 20650 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. <i>Carcinomatous</i>
b. <i>Lung Cancer</i>
c.
d. | | | | | | | | Approximate Interval Between Onset and Death

<i>yr.
yr +</i> | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
<i>James P. Jarboe</i> | | | | 29c. License number
D 06419 | | 29d. Date signed (Month, Day, Year)
5-10-99 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
James P. Jarboe, MD Hollywood, MD 20636 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 10 1999 | | 32. Registrar's Signature
<i>Benita S. Sparks</i> | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17921

| | | | | | | | | |
|---|---|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
William Matthew Herbert | | | | 2. Date of Death
Month Day Year
MAY 20, 1999 | | 3. Time of Death
1000 AM | |
| | 4a. Facility Name (If not institution, give street and number)
12901 WHEATLAND WAY | | | | 4b. City, Town, or Location of Death
BRANDYWINE | | 4c. County of Death
PRINCE GEORGES | |
| Funeral
Director | 5. Social Security Number
220-78-0717 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
37 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 5, 1962 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
n/a | | 10b. County
n/a | | 10c. City, Town or Location
Washington, D.C. | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 10e. Street and Number
1847 Massachusetts Avenue, SE, #3 | | 10f. Zip Code
20003 | |
| | 10g. Citizen of What Country?
United States | | | | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Truck Driver | | | | 16b. Kind of Business/Industry
Retail Delivery | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Charles Joseph Herbert, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Frances Louise Stewart | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Frances Louise Herbert, Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
40750 Kings Drive, Mechanicsville, MD 20659 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify): | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Charles Memorial Gardens | | 20c. Location - City or Town, State
Leonardtown, Maryland | |
| | 21. Signature of Funeral Service Licensee
MAY B. RIZZO | | | | 22. Name and Address of Facility
Brinsfield Funeral Home, P.A.
22955 Hollywood Rd., Leonardtown, MD 20650-0279 | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. CARCINOMA OF THE LUNG
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
INSPECTION
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
J. Smialek | | | |
| To Be Completed by Physician/Medical Examiner | 29c. License number
O.C.M.E. | | | | 29d. Date signed (Month, Day, Year)
MAY 25, 1999 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOHN E. SMIALEK M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | 31. Date filed (Month, Day, Year)
MAY 28 1999 | | | |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature
B. Jones | | | | 33. State Registrar
MAY 28 1999 | | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17922

| | | | | | | | | | |
|--|--|--|---|---|--|--|--|-----------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Charles Edward Johnson Jr. | | | | 2. Date of Death
Month Day Year
May 6 1999 | | 3. Time of Death
8:30 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
118 Marryman Court | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | | |
| Funeral
Director | 5. Social Security Number
216-12-4628 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (in yrs. last birthday)
75 Yrs. | | 8. Date of Birth (Month, Day, Year)
6-24-23 | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Md | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Annapolis | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
118 Marryman Court | | 10f. Zip Code
21401 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 4/17/43 to 1-8-46 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Carpenter | | 16b. Kind of Business/Industry
Anne Arundel Co. | | | | |
| | 17. Father's Name (First, Middle, Last)
Charles Edward Johnson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Florence Murray | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Barbara Johnson - Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
118 Marryman Ct. Annapolis, Md. 21401 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cakemant Cemetery | | 20c. Location - City or Town, State
5-10-99 Davisville, Md | | 20d. Date
1922 Forest Drive
Annapolis, Md. | | |
| | 21. Signature of Funeral Service Licensee
Jeff Miller | | | | 22. Name and Address of Facility
House of Hicks F/H | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Epiglottic Cancer
Due to (or as a consequence of):
Tobacco Use
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Chronic Obstructive Pulmonary Dz,
HTN | | | | Approximate Interval Between Onset and Death
5 yrs | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Dz,
HTN | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
David C. Anderson | | 29c. License number
D43236 | |
| 29d. Date signed (Month, Day, Year)
5/12/99 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David C. Anderson 2448 Holly Ave Suite 100 Annapolis, MD 21401 | | 31. Date filed (Month, Day, Year)
MAY 17 1999 | | 32. Registrar's Signature
B. Spaulding | | | |

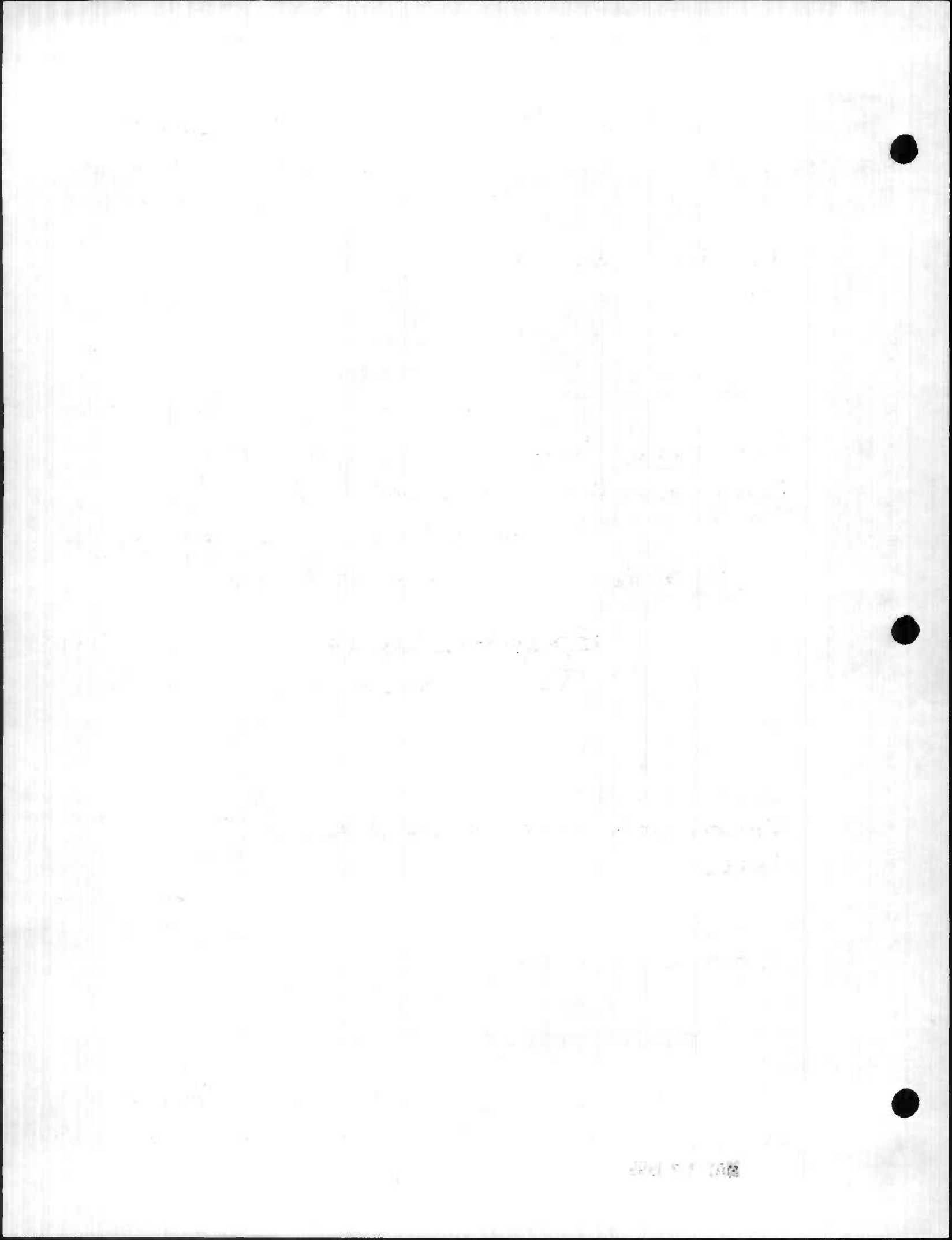
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-0000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17923

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Betty Helen Ketterman

2. Date of Death

MAY

Day

17

Year

1999

3. Time of Death

11:05 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Berlin Nursing & Rehabilitation Center

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

5. Social Security Number

221-18-6072

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

10/17/1928

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

Delaware

10b. County

Sussex

10c. City, Town or Location

Frankford

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Rt. 3 Box 195

10f. Zip Code

19945

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

Collage (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

poultry grower

16b. Kind of Business/Industry

poultry industry

17. Father's Name (First, Middle, Last)

Oscar Hudson

18. Mother's Name (First, Middle, Maiden Surname)

Lillie Brittingham

19a. Informant's Name/Relationship (Type, Print)

Judy Smack - niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7328 Division St., Willards, Md. 21874

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dagsboro Redmen's Cem.

Date

5/20/99

20c. Location - City or Town, State

Dagsboro, Delaware

21. Signature of Funeral Service Licensee

Richard T. Watson

22. Name and Address of Facility

Watson Funeral Home, Inc.

Millsboro, Delaware 19966

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of Right Maxillary Sinus. 2 months.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

H/O Adenocarcinoma of Endometrium
Insulin Dependent Diabetes Mellitus
Coronary Artery Disease/Myocardial Infarction

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

F. Arthes

29c. License number

D02026

29d. Date signed (Month, Day, Year)

5-18-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEDERICO G. ARTHES, MD 46 TEAL CIRCLE BERLIN MD 21811 410-641-4400

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

Benita B Sparks

State
Registrar

BETTY KETTERMAN

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12

The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that every entry, no matter how small, should be recorded to ensure the integrity of the financial data. This includes not only sales and purchases but also expenses and income. The second part of the document provides a detailed breakdown of the company's financial performance over the last quarter. It includes a comparison of actual results against budgeted figures, highlighting areas of strength and areas needing improvement. The third part of the document outlines the company's financial goals for the upcoming year, focusing on increasing revenue, reducing costs, and improving overall profitability. It also discusses the strategies and initiatives that will be implemented to achieve these goals. The final part of the document provides a summary of the key findings and recommendations, emphasizing the need for continued vigilance and attention to financial details.

The following table provides a detailed breakdown of the company's financial performance over the last quarter. It includes a comparison of actual results against budgeted figures, highlighting areas of strength and areas needing improvement. The table is organized into columns for various financial metrics, including sales, expenses, and net income. The data shows that while sales were slightly below budget, expenses were well-controlled, resulting in a net income that was slightly above budget. This indicates that the company's cost management strategies are effective, but there is still room for improvement in sales performance. The table also includes a section for the company's financial goals for the upcoming year, focusing on increasing revenue, reducing costs, and improving overall profitability. It also discusses the strategies and initiatives that will be implemented to achieve these goals. The final part of the document provides a summary of the key findings and recommendations, emphasizing the need for continued vigilance and attention to financial details.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

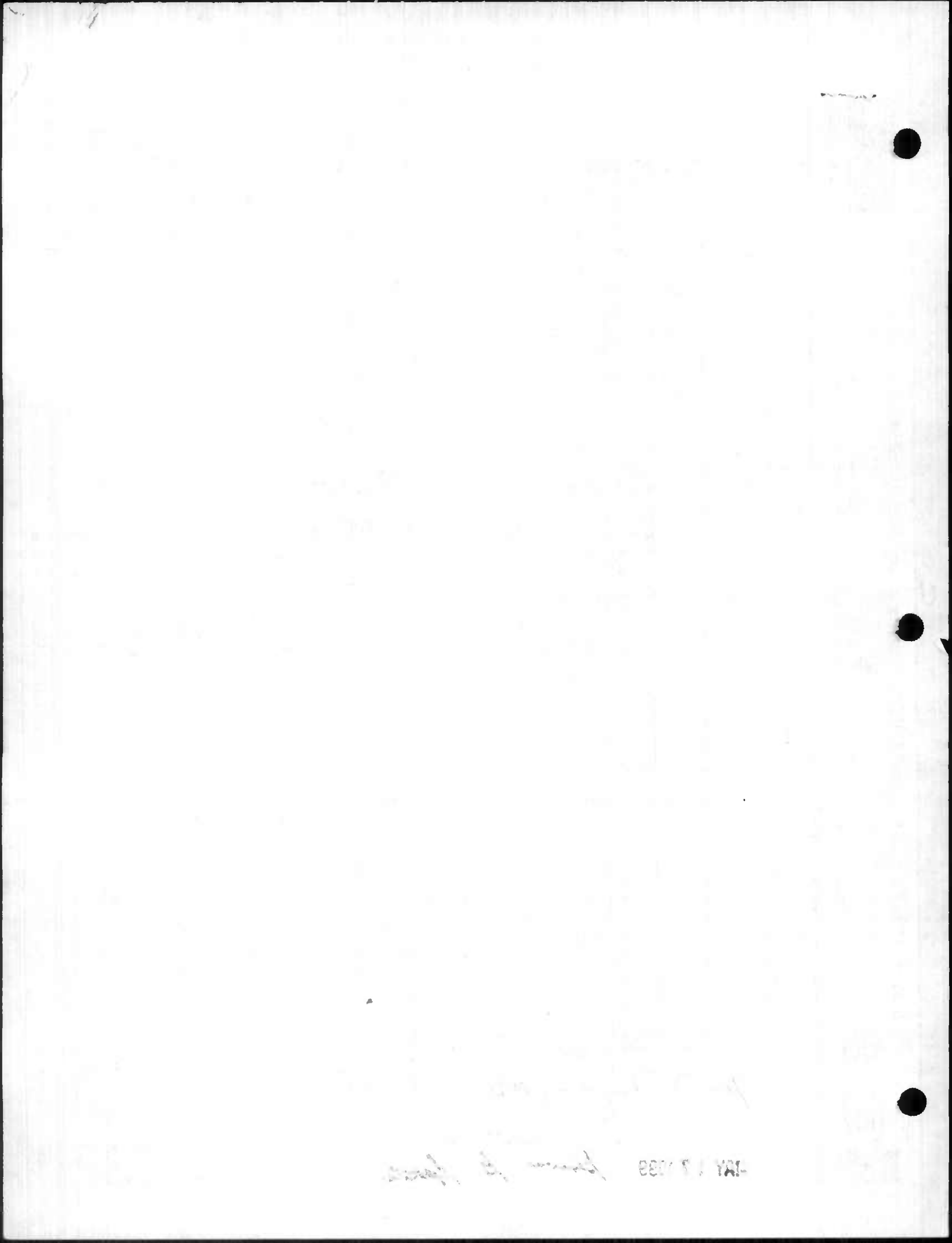
Reg. No.

99 17926

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|---|--|--|--|--|--|---|----|--------------------------------------|------------|----------------------------------|--|--|----|-----------------|---------|----------------------------------|--|--|--|----|--|--|----|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ALISON RUTH KAPLAN | | | | 2. Date of Death
Month: May Day: 9 Year: 1999 | | 3. Time of Death
3:55 PM | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
NIH, The Clinical Center | | | | 4b. City, Town, or Location of Death
Bethesda | | 4c. County of Death
Montgomery | | | | | | | | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
228-49-2532 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
12 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 24, 1987 | | | | | | | | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country)
Virginia | | 10a. State
Virginia | | 10b. County
James City | | 10c. City, Town or Location
Williamsburg | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
107 Sabre Drive | | 10f. Zip Code
23185 | | 10g. Citizen of What Country?
U.S.A. | | | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6th Grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Student | | 16b. Kind of Business/Industry
James Blair Elementary | | | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Robert E. Kaplan | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Barbara Domansky | | | | | | | | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Robert E. Kaplan, Father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
107 Sabre Drive, Williamsburg, Virginia 23185 | | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Williamsburg Memorial Park | | 20c. Location - City or Town, State
Williamsburg, Virginia | | 20d. Date
May 12, 1999 | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
<i>Reginald B.</i> | | | | 22. Name and Address of Facility
STEIN HEBREW MEMORIAL FUNERAL HOME, INC.
232 CARROLL STREET, NW, WASHINGTON, DC 20012 | | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>INVASIVE ASPERGILLUS SINUS INFECTION</td> <td>2.5 MONTHS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td>APLASTIC ANEMIA</td> <td>2 YEARS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. | INVASIVE ASPERGILLUS SINUS INFECTION | 2.5 MONTHS | Due to (or as a consequence of): | | | b. | APLASTIC ANEMIA | 2 YEARS | Due to (or as a consequence of): | | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. | | | d. | | |
| | Immediate Cause (Final disease or condition resulting in death) | a. | INVASIVE ASPERGILLUS SINUS INFECTION | 2.5 MONTHS | | | | | | | | | | | | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. | | APLASTIC ANEMIA | 2 YEARS | | | | | | | | | | | | | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | | | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Janet N. Myers, MD</i> | | | | 29c. License number
0101051315 VA | | 29d. Date signed (Month, Day, Year)
May 14, 1999 | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Janet N. Myers, MD, 9000 Rockville Pike, Bethesda, Maryland 20892 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1999 | | 32. Registrar's Signature
<i>James B. Jones</i> | | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



2001 5 / YAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17925

| | | | | | | | | |
|--|--|---|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Adolph Kautz | | | | 2. Date of Death
Month Day Year
May 14, 1999 | | 3. Time of Death
14:42 | |
| | 4a. Facility Name (If not institution, give street and number)
Bowie Health Center | | | | 4b. City, Town, or Location of Death
Bowie | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
394-18-6512 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
79 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Feb. 25, 1920 | 9. Birthplace (State or Foreign Country)
Wisconsin |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Bowie | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
13206 Overbrook Lane | | | | 10f. Zip Code
20715 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Engineer | | 18b. Kind of Business/Industry
U.S. Gov't | | |
| 17. Father's Name (First, Middle, Last)
unknown Kautz | | | | 18. Mother's Name (First, Middle, Maiden Surname)
unknown Julich | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Erica Christman | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
802 Pineview Trails Court Ballwin, MO 63021 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | Data
5/17/99 | | 20c. Location - City or Town, State
Alexandria, Virginia | | |
| 21. Signature of Funeral Service Licensee
<i>Michael L. Bogle</i> | | | | 22. Name and Address of Facility
Robert E. Evans Funeral Home, Inc.
16000 Annapolis Road Bowie, MD 20715 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary fibrosis. / Hypoxia
Due to (or as a consequence of):
b. Tobacco abuse
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d. | | | | | | | | Approximate Interval Between Onset and Death
years
years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Anemia
Colonic bleeding
Prostate cancer | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Thomas F. Hattar</i> | | | | | | |
| 29c. License number
00050321 | | 29d. Date signed (Month, Day, Year)
5/14/99 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Thomas Hattar, MD 3231 Superior Ln. Bowie, MD 20715 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 18 1999 | | 32. Registrar's Signature
<i>Anne B. Smith</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

(15)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17926

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George Lawrence Layman

2. Date of Death

May 23, 1999

3. Time of Death

1930

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

219-14-5508

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

14-Feb-24

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Frostburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

202 Braddock Heights

10f. Zip Code

21532-

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Road foreman

16b. Kind of Business/Industry

State highway dept.

17. Father's Name (First, Middle, Last)

George H. Layman

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Long

19a. Informant's Name/Relationship (Type, Print)

Mary M. Layman Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

202 Braddock Heights Frostburg Maryland 21532-

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Saint Michael's Parish Cemetery

Data

26-May-99

20c. Location - City or Town, State

Frostburg, Maryland

21. Signature of Funeral Service Licensee

John R. Durst

22. Name and Address of Facility

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Renal carcinoma, metastatic

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

Arteriosclerosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John R. Durst MD

29c. License number

D12532

29d. Date signed (Month, Day, Year)

May 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

912 Seton Drive, Cumberland, MD 21502 (Dr. Breza)

31. Date filed (Month, Day, Year)

MAY 26 1999

32. Registrar's Signature

Benjamin S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

George Lawrence Layman

Georgetown Hospital

212-14-2208

72

14-Feb-24

Maryland

Allegany

Cumberland

Maryland Allegany Frostburg

303 Broadrock Heights

21232-

U.S.A.

White

12

Road foreman

State Highway Dept.

George H. Layman

Catherine Long

Mary M. Layman

Wife

303 Broadrock Heights

Frostburg

Maryland 21232-

St. Michael's Parish Cemetery

26-May-99

Frostburg, Maryland

Dust Funeral Home, 52 First Ave., Frostburg, MD 21232

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17927

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lewis Alvin LOHR

2. Date of Death

May 15, 1999

3. Time of Death

4:45 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Ortiz Personal Care Home

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

5. Social Security Number

213-24-5025

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 30, 1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

21550

10c. City, Town or Location

Swanton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

171 Beckman-Lohr Road

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
7th

College (1-4or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Farming

17. Father's Name (First, Middle, Last)

Alfred ----- Lohr

18. Mother's Name (First, Middle, Maiden Surname)

Susan ----- O'Brien

19a. Informant's Name/Relationship (Type, Print)

Ethel F. Hines/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

171 Beckman-Lohr Road, Swanton, MD 21561

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Alexander Lohr Cem.

Date

5/18/99

20c. Location - City or Town, State

Swanton, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stewart Funeral Home

32 S. Second St., Oakland, MD 21550

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Arteriosclerotic Cardiovascular Heart Disease

Years

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebral Vascular Accident

Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Personal Care Home

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and Title of Certifier

29c. License number

H26154

29d. Date signed (Month, Day, Year)

5/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. P. Daniel Miller, DO 69 Wolf Acres Road, Oakland, Maryland 21550

State
Registrar

31. Date filed (Month, Day, Year)

MAY 17 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17928

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LOUISE M. LYNN

2. Date of Death
Month Day Year
MAY 6, 19993. Time of Death
9:30 P.M.Funeral
Director

4a. Facility Name (If not institution, give street and number)

HCR-MANOR CARE

4b. City, Town, or Location of Death

LARGO

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

579-40-6720

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAY 1, 1908

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

UPPER MARLBORO

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

600 LARGO ROAD

10f. Zip Code

20772

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
9

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

PRODUCTION WORKER

16b. Kind of Business/Industry

MEDICINE PLANT

17. Father's Name (First, Middle, Last)

MARTIN DINGES

18. Mother's Name (First, Middle, Maiden Surname)

MAE MARGURIET ROLPH

19a. Informant's Name/Relationship (Type, Print)

HUBERT VAUGHN, SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3306 ROYALE GLEN AVENUE, DAVIDSONVILLE, MD 21035

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

FORT LINCOLN CEMETERY

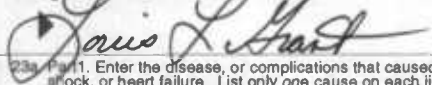
Date

5/10/99

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

FORT LINCOLN FUNERAL HOME

3401 BLADENSBURG RD., BRENTWOOD, MD 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
stroke, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. RESPIRATORY FAILURE

2 WEEKS

Due to (or as a consequence of):

b. CONGESTIVE HEART FAILURE

10 DAYS

Due to (or as a consequence of):

c. DEEP VENOUS THROMBOSIS

10 DAYS

Due to (or as a consequence of):

d.

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

PULMONARY EMBOLISM

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

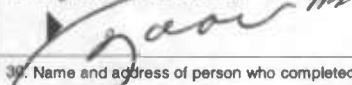
28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier



29c. License number

D34722

29d. Date signed (Month, Day, Year)

MAY 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VICKEN POOCHIKIAN, M.D., 5632 ANNAPOLIS ROAD, #3, BLADENSBURG, MARYLAND 20710

31. Date filed (Month, Day, Year)

MAY 17 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

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within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Page 1

1. The first part of the report deals with the general situation of the country. It is a very interesting and informative study of the country's development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's development.

2. The second part of the report deals with the economic situation of the country. It is a very interesting and informative study of the country's economic development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's economic development.

3. The third part of the report deals with the social situation of the country. It is a very interesting and informative study of the country's social development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's social development.

99-2848-031

99-105

ITEMS: #23 PART I, 27, 28A-F PER MEU 6771 6-9-99 WR.
Christopher Leroy Leak

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17029

| | | | | | | | | | | |
|---|---|--|--|---|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Christopher Leroy Leak | | | | 2. Date of Death
Month Day Year
MAY 17, 1999 | | 3. Time of Death
8:39A.M. | | | |
| | 4a. Facility Name (If not institution, give street and number)
WASHINGTON ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death
TAKOMA PARK | | 4c. County of Death
MONTGOMERY | | | |
| Funeral
Director | 5. Social Security Number
219-72-2047 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
32 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 3, 1967 | | | |
| | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Hyattsville | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| Usual Residence of Decedent | | | | 10e. Street and Number
4903 69th Place | | 10f. Zip Code
20784 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th grade
College (14 or 5+) _____ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Clerk | | | 16b. Kind of Business/Industry
Burger King Restaurant | | | |
| 17. Father's Name (First, Middle, Last)
Thomas A. Henry | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Peggy Juddy | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Ms. Peggy J. Williams (Mother) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4903 69th Place, Hyattsville, Maryland 20784 | | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory, Inc. | | | Data
5/25/99 | | 20c. Location - City or Town, State
Beltsville, Maryland | | |
| 21. Signature of Funeral Service Licensee
<i>Janet C. Induser</i> | | | | 22. Name and Address of Facility
Rollins Funeral Home, Inc.
4339 Hunt Place, N.E. Washington, D.C. 20019 | | | | | | |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC ARRHYTHMIA
Due to (or as a consequence of):
b. COCAINE EXCITED DELIRIUM DURING RESTRAINT
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year)
5-16-99 | | 28b. Time of Injury
UNKNOWN M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
UNKNOWN | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
UNKNOWN | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
7600 NEW HAMPSHIRE AVE.
MONTGOMERY COUNTY, MD | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | 29c. License number
O.C.M.E. | |
| 29b. Signature and title of certifier
<i>Joseph Pestaner, M.D.</i> | | | | | | | | | 29d. Date signed (Month, Day, Year)
MAY 18, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner, M.D.
111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 26 1999 | | | 32. Registrar's Signature
<i>James B. Sparks</i> | | | | | | | |

Baltimore, Maryland 21215-0020

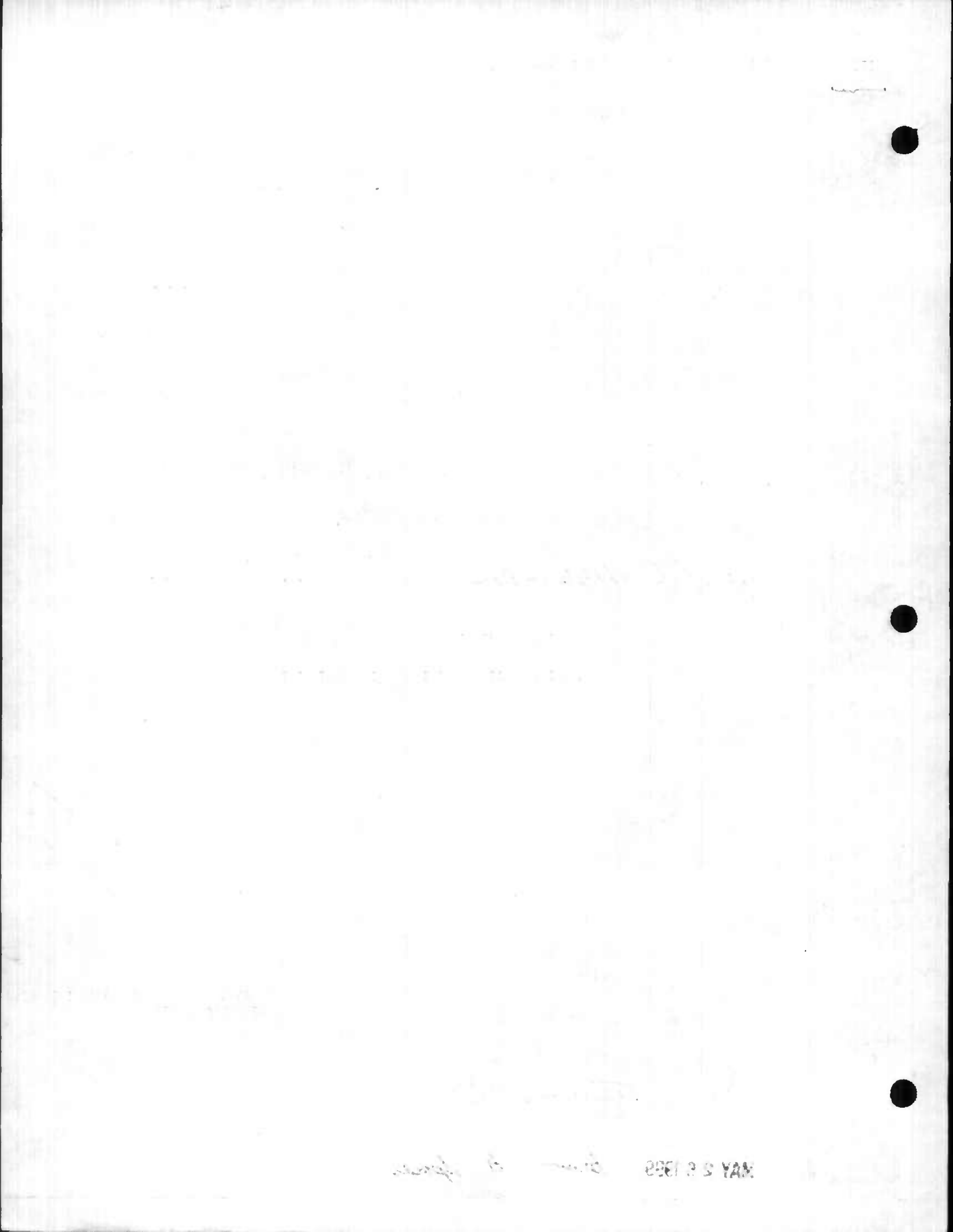
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17930

| | | | | | | | | | | |
|---|---|---|---|--------------------------------|---|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Susie Florence Lewis | | | | 2. Date of Death
Month Day Year
May 15 1999 | | 3. Time of Death
22:10 PM | | | |
| | 4a. Facility Name (If not institution, give street and number)
Holy Cross Hospital | | | | 4b. City, Town, or Location of Death
Silver Spring | | 4c. County of Death
Montgomery | | | |
| Funeral
Director | 5. Social Security Number
579-44-9529 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
89 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
July 7, 1909 | | 9. Birthplace (State or Foreign Country)
Virginia | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
District of Columbia | | 10b. County
Washington | | 10c. City, Town or Location
Washington | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 10e. Street and Number
649 E St., N.E. | | | 10f. Zip Code
20002 | | 10g. Citizen of What Country?
United States | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Beautician | | 16b. Kind of Business/Industry
Self-Employed | | | | | |
| | 17. Father's Name (First, Middle, Last)
Charlie Givens | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Unknown | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Ruth Givens - Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5244 Longbridge Rd., Richmond, VA 23231 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ft. Lincoln Cemetery | | Date
5/22/99 | | 20c. Location - City or Town, State
Brentwood, MD | | | |
| | 21. Signature of Funeral Service Licensee
<i>John T. Stewart III</i> | | | | 22. Name and Address of Facility
Stewart Funeral Home
4001 Benning Rd., N.E. Wash., D.C. 20019 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>Arrhythmia</i>

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
<i>Reo. murmur</i>

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death
<i>Reo. murmur</i> | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>G. Chabiani</i> | | | | 29c. License number
D42518 | | 29d. Date signed (Month, Day, Year)
MAY 16, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GUL CHABIANI, 11119 ROCKVILLE PIKE #401, ROCKVILLE MD 20852 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 19 1999 | | 32. Registrar's Signature
<i>B. Jones</i> | | | | | | | | |

2000 10 10 1000 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17931

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Josephine L. Lester

2. Date of Death

Month

Day

Year

May

13

1999

3. Time of Death

11:45 PM

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

161-22-1302

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Nov. 26, 1925

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Lanham

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

9309 Washington Blvd.

10f. Zip Code

20706

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Information Specialist

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Joseph M. Mako

18. Mother's Name (First, Middle, Maiden Surname)

Mary Povanda

19a. Informant's Name/Relationship (Type, Print)

Joseph Lester/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12412 Poplar View Dr. Bowie, MD 20720

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Maryland Veterans Cemetery

Date

5/18/99

20c. Location - City or Town, State

Cheltenham

21. Signature of Funeral Service Licensee

Todd Liller

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.

16000 Annapolis Rd. Bowie, MD 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. SEVERE CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. CARDIOMYOPATHY

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

EMPHYSEMA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

H. Mako

29c. License number

A21883

29d. Date signed (Month, Day, Year)

5/14/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HEMA P. YASLAM D. 9470 ANNA POLIS RD SUITE # 308 LANHAM MD

31. Date filed (Month, Day, Year)

MAY 18 1999

32. Registrar's Signature

B. S. Jones

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17932

Amend # 8. Per FH PGC 5-19-99 cr

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

DENNIS JEROME LANDIS, SR.

2. Date of Death

Month

Day

Year

05

12

99

3. Time of Death

2:30 am

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

215-36-4868

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

58

8. Date of Birth

Month

Day

Year

9. Birthplace (State or Foreign Country)

September 9, 1940

November

10. Inside City Limits

☒ Yes ☐ No

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Brentwood

10e. Street and Number

4011 38th Street, #1

10f. Zip Code

20722

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Rufus Landis

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Patterson

19a. Informant's Name/Relationship (Type, Print)

Denise Thomas/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4027 35th Street, Mt. Rainer, Maryland 20712

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park Cemetery

Date

05/17

1999

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Debra J. Jenkins

22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME
7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. cardiac Arrhythmia

Due to (or as a consequence of):

b. Metastatic Lung Carcinoma

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☒ DOA

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Anil K. Mahajan MD

29c. License number

D50689

29d. Date signed (Month, Day, Year)

05/12/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anil K. Mahajan, M.D. 3001 Hospital Drive, Cheverly, Maryland 20785

31. Date filed (Month, Day, Year)

MAY 17 1999

32. Registrar's Signature

Debra J. Jenkins

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

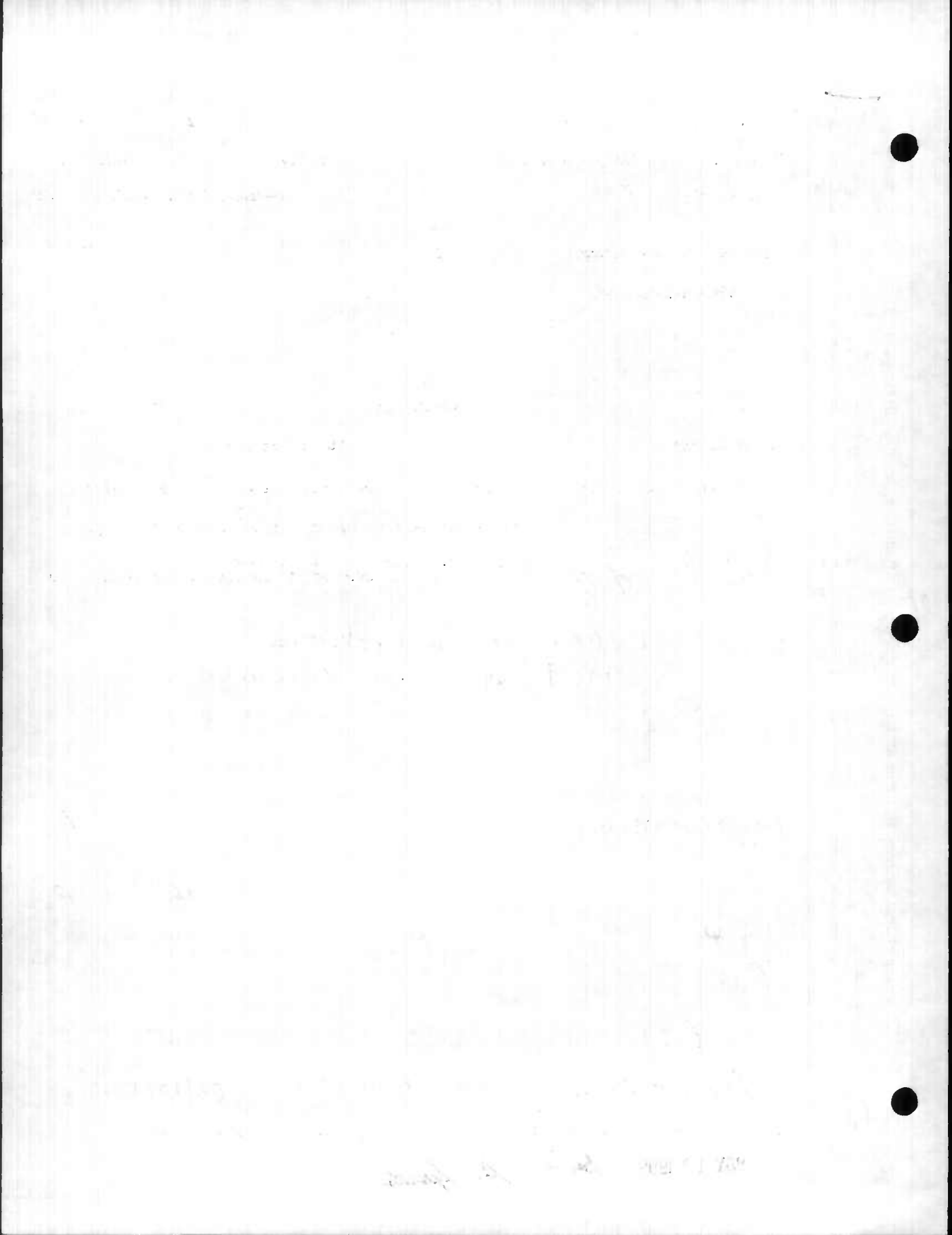
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

JEFFREY

State of Maryland / Department of Health and Mental Hygiene

McALLISTER

ITEMS: #23 PART 1, 27 PER MD G772 6-14-99 W

Certificate of Death

Reg. No.

99 17933

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jeffrey Scott McAllister

2. Date of Death

Month
MAYDay
11, 1999

3. Time of Death

6:25P.M.

4a. Facility Name (If not institution, give street and number)

3906 NORWALK PLACE

4b. City, Town, or Location of Death

BOWIE

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

214-92-4497

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

35 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 10, 1964

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3906 Norwalk Place

10f. Zip Code

20716

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Automobile

17. Father's Name (First, Middle, Last)

Harry B. McAllister

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Ann Paddy

19a. Informant's Name/Relationship (Type, Print)

Margaret Ann Norton / mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1583 Comanche Rd. Arnold, MD 21012

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

5-15-99

20c. Location - City or Town, State

Brentwood, MD.

21. Signature of Funeral Service Licensee

C. Brian Powell

22. Name and Address of Facility

John M. Taylor Funeral Home, Inc.
147 Duke of Gloucester St. Annapolis, MD 2140123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

ADDISON'S DISEASE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

a.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen S. Radentz, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

MAY 12, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radentz

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 17 1999

32. Registrar's Signature

B. A. A. A.

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

END OF LINE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-17934

| | | | | | | | | | |
|--|---|---|---|--------------------------------------|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Kenneth Emmett Musselman, Sr. | | | | 2. Date of Death
Month Day Year
May 16, 1999 | | 3. Time of Death
6:37 A.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | | |
| Funeral
Director | 5. Social Security Number
578-42-4879 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
66 | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
March 7, 1933 | 9. Birthplace (State or Foreign Country)
Washington, DC | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Churchton | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
1134 Delaware Avenue | | | | 10f. Zip Code
20733 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1951-52 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
12th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Repairman | | 16b. Kind of Business/Industry
Office Machines | | | | |
| | 17. Father's Name (First, Middle, Last)
George Clifton Musselman | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Louise Ollie Wood | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Kimberly D. Roberts/ Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1134 Delaware Avenue Churchton, MD 20733 | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | Date
5-19-99 | | 20c. Location - City or Town, State
Alexandria, Virginia | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility
George P. Kalas Funeral Home
2973 Solomons Island Rd. Edgewater, MD 21037 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Cerebral Vascular Accident
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | Approximate Interval Between Onset and Death
3 days | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Wayne Bierbaum, MD | | 29c. License number
D38563 | | 29d. Date signed (Month, Day, Year)
May 16, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wayne Bierbaum 134 Owensville Road, West River, MD | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 19 1999 | | 32. Registrar's Signature
B. Sparks | | | | | | | |

mcg Baltimore, Maryland 21215-0020

permit. Entries 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17935

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Winona K. Miller

2. Date of Death

May 8, 1999

3. Time of Death

3:30 PM

4a. Facility Name (If not institution, give street and number)

16200 Old Beechwood Rd.

4b. City, Town, or Location of Death

Lonaconing

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

213-74-4889

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 9, 1904

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Allegany

10c. City, Town or Location

Lonaconing

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

16200 Old Beechwood Rd.

10f. Zip Code

21539

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
Unknown

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Guy Richardson

18. Mother's Name (First, Middle, Maiden Surname)

Exie C. Koontz

19a. Informant's Name/Relationship (Type, Print)

Donald Miller / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 255 Midland, MD 21542

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mountain View Cemetery

Date

5/11/99

20c. Location - City or Town, State

Moscow Mills, MD

21. Signature of Funeral Service Licensee

7 Wayne Boal

22. Name and Address of Facility

111 Church St.
Boal Funeral Home Westernport, MD 2156223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

8 YEARS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

VALVULAR HEART DISEASE

BRONCHOSPASM

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner as stated.

29b. Signature and title of certifier

Robert Welik

29c. License number

D31875

29d. Date signed (Month, Day, Year)

MAY 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Welik, MD 902 Seton Drive Suite 308 Cumberland, MD 21502

31. Date filed (Month, Day, Year)

MAY 13 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1+2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

17936

| | | | | | | | | |
|---|--|---|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JACQULIN FAY MOORE | | | | 2. Date of Death
Month Day Year
May 14, 1999 | | 3. Time of Death
7:00 PM | |
| | 4a. Facility Name (If not institution, give street and number)
305 New York Ave. | | | | 4b. City, Town, or Location of Death
Salisbury | | 4c. County of Death
Wicomico | |
| Funeral
Director | 5. Social Security Number
217-30-9457 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
63 Yrs. | | 8. Date of Birth (Month, Day, Year)
August 19, 1935 | |
| | 9. Birthplace (State or Foreign Country)
Georgia | | 10a. State
Maryland | | 10b. County
Wicomico | | 10c. City, Town or Location
Salisbury | |
| Usual Residence of Decedent | | 10e. Street and Number
305 New York Ave. | | 10f. Zip Code
21801 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Advertising Supervisor | | 16b. Kind of Business/Industry
Newspaper | | | | |
| 17. Father's Name (First, Middle, Last)
Luther B. Moore II | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lilyan Wilkes | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Luther B. Moore III/Brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
35 Bay Reach, Rehobeth Beach, DE 19971 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Salisbury Crematory | | 20c. Location - City or Town, State
Salisbury, MD | | 20d. Date
5/17/99 | | |
| 21. Signature of Funeral Service Licensee
<i>David H. Thompson</i> MO1051 | | 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. chronic obstructive pulmonary disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
20 years | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Charles B. Silva Jr</i> | | 29c. License number
D30853 | | 29d. Date signed (Month, Day, Year)
5/17/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Charles B. Silva Jr 100 Power St. Salisbury MD 21804 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1999 | | 32. Registrar's Signature
<i>Beverly B. Sparks</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23b-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17937

| | | | | | | | | |
|---|---|--|---|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LELAH FRANCES MCKENZIE | | | | 2. Date of Death
Month 5 Day 15 Year 99 | | 3. Time of Death
0635 | |
| | 4a. Facility Name (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
SALISBURY | | 4c. County of Death
WICOMICO | |
| Funeral
Director | 5. Social Security Number
412-03-8201 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
83 | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
August 13, 1915 | 9. Birthplace (State or Foreign Country)
Mississippi |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Wicomico | | 10c. City, Town or Location
Salisbury | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
1206 Taney Ave. | | | | 10f. Zip Code
21801 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Volunteer coordinator | | | 16b. Kind of Business/Industry
Deer's Head Hospital | | |
| | 17. Father's Name (First, Middle, Last)
Robert Harry McClain | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lelah Risher Price | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Victor Frank McKenzie/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1014 Camden Ave., Salisbury, MD 21801 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springhill Memory Gardens | | Date
5/18/99 | | 20c. Location - City or Town, State
Hebron, MD | |
| | 21. Signature of Funeral Service Licensee
<i>David H. Thompson</i> MD1051 | | 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. cardiac arrest
Due to (or as a consequence of):
b. lung cancer
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| State
Registrar | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier
<i>Joseph Inzerillo</i> | | | | 29c. License number
D47637 | | 29d. Date signed (Month, Day, Year)
5-16-99 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Joseph Inzerillo 106 Milford Street Salisbury, MD 21801 | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1999 | | | | 32. Registrar's Signature
<i>Sparks</i> | | | | |

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

1. The first part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into columns, with names in the first column and addresses in the second column. The names are: John Doe, Jane Smith, Robert Brown, Mary White, and Thomas Green. The addresses are: 123 Main Street, New York, NY 10001; 456 Elm Street, New York, NY 10002; 789 Oak Street, New York, NY 10003; 101 Pine Street, New York, NY 10004; and 202 Cedar Street, New York, NY 10005.

2. The second part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into columns, with names in the first column and addresses in the second column. The names are: John Doe, Jane Smith, Robert Brown, Mary White, and Thomas Green. The addresses are: 123 Main Street, New York, NY 10001; 456 Elm Street, New York, NY 10002; 789 Oak Street, New York, NY 10003; 101 Pine Street, New York, NY 10004; and 202 Cedar Street, New York, NY 10005.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17938

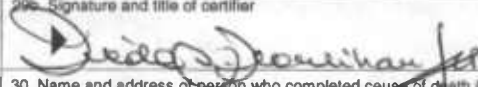
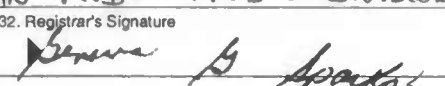
| | | | | | | | | |
|--|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
IRENE MCKENZIE | | | | 2. Date of Death
Month Day Year
May 16, 1999 | | 3. Time of Death
12:37 AM | |
| | 4a. Facility Name (If not institution, give street and number)
320 Poplar Hill Ave. | | | | 4b. City, Town, or Location of Death
Salisbury | | 4c. County of Death
Wicomico | |
| Funeral
Director | 5. Social Security Number
220-66-4436 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
72 Yrs. | | 8. Date of Birth (Month, Day, Year)
February 6, 1927 | |
| | 9. Birthplace (State or Foreign Country)
Jamaica, West Indies | | 10a. State
Maryland | | 10b. County
Wicomico | | 10c. City, Town or Location
Salisbury | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
320 Poplar Hill Ave. | | 10f. Zip Code
21801 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Jamaican | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) - | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Child Care Provider | | 16b. Kind of Business/Industry
Child Care | | | | |
| 17. Father's Name (First, Middle, Last)
Nathaniel Mitchell | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ellen Paisley | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Felix J. McKenzie/Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
320 Poplar Hill ave., Salisbury, MD 21801 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springhill Memory Gardens | | 20c. Date
5/21/99 | | 20d. Location - City or Town, State
Hebron, MD | | |
| 21. Signature of Funeral Home Licensee
 | | | | 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Neuroendocrine tumor.
Due to (or as a consequence of):

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Approximate Interval Between Onset and Death
year. | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION
Hiatal Hernia & Gastroesophageal Reflux | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
D 04883 | | 29d. Date signed (Month, Day, Year)
May 18, 99. | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HILDA J. HOULIHAN M.D. 1405 S. Division St Salisbury MD, 21804 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 19 1999 | | 32. Registrar's Signature
 | | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-17939

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VIRGINIA

NIBLETT

McGEE

2. Date of Death
Month Day Year

May 14 1999

3. Time of Death

0947

Funeral
Director

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

215-26-4037

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

OCT. 24, 1928

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

WORCESTER

10c. City, Town or Location

WHALEYVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11603 SHEPPARDS CROSSING ROAD

10f. Zip Code

21872

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

SELBY H. NIBLETT

18. Mother's Name (First, Middle, Maiden Surname)

VIRGIE R. DAVIS

19a. Informant's Name/Relationship (Type, Print)

FREDERICK R. McGEE/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 25, WHALEYVILLE, MARYLAND 21872

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DALE CEMETERY

Date

5/17/99

20c. Location - City or Town, State

WHALEYVILLE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D34768

29d. Date signed (Month, Day, Year)

5/14/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JERRAL NIELAND, M.D. 400 E SHORE DR SALISBURY, MD

31. Date filed (Month, Day, Year)

MAY 17 1999

32. Registrar's Signature

Benita S. Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

215-26-4037

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Virginia N. McGee

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

17940

Physician / Medical Examiner
Funeral Director

| | | | | | | | |
|---|--|---|---|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
GEORGE WASHINGTON MCCOY | | | | 2. Date of Death
Month Day Year
MAY 16 1999 | | 3. Time of Death
7:45 am | |
| 4a. Facility Name (If not institution, give street and number)
ALTHEA WOODLAND NURSING HOME | | | | 4b. City, Town, or Location of Death
SILVER SPRING | | 4c. County of Death
MONTGOMERY | |
| 5. Social Security Number
228 14 3780 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
77 Yrs. | 8. Date of Birth (Month, Day, Year)
January 11, 1922 | 9. Birthplace (State or Foreign Country)
Virginia | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State
Virginia | | 10b. County
Northumberland | | 10c. City, Town or Location
Callao | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
Route 1 Box 276 | | | | 10f. Zip Code
22435 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Waterman | | 16b. Kind of Business/Industry
Smith Industries | |
| 17. Father's Name (First, Middle, Last)
Frank A. McCoy | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Rose Gordon | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Betty S. McCoy / wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
921 Lively Hope Rd. Callao, VA 22435 | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lively Hope Church Cem. | | 20c. Location - City or Town, State
5-22-99 Callao, Virginia | | | |
| 21. Signature of Funeral Service Licensee
<i>Shirley C. Briscoe-Tonic</i> | | | | 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MD
4308 Suitland Road Suitland, MD 20746 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. ACUTE GASTROINTESTINAL BLEEDING
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
f. Due to (or as a consequence of):
g. Due to (or as a consequence of):
h. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown

24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No

24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier
<i>Smith S. Ho</i> | | | | 29c. License number
D-21900 | | 29d. Date signed (Month, Day, Year)
May 19, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SMITH S. HO 7610 Carroll Avenue #280 Takoma Park, MD 20912 | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 21 1999 | | | | 32. Registrar's Signature
<i>James B. Smith</i> | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17941

| | | | | | | | | |
|---|---|---|---|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Beverly T. Miller | | | | 2. Date of Death
Month Day Year
May 13, 1999 | | 3. Time of Death
18:44 | |
| | 4a. Facility Name (If not institution, give street and number)
Washington Adventist Hospital | | | | 4b. City, Town, or Location of Death
Takoma Park | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
578-66-4782 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
51 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
October 22, 1947 | | 9. Birthplace (State or Foreign Country)
Washington, D.C. |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
D.C. | 10b. County | | 10c. City, Town or Location
Washington | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number
1553 Anacostia Avenue, N.E. Apt. #32 | | | | 10f. Zip Code
20019 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Head Cook | | 16b. Kind of Business/Industry
University Of Maryland | | | |
| | 17. Father's Name (First, Middle, Last)
Samuel Miller | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Jannie Brown | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Tari Miller (Sister) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1553 Anacostia Avenue, N.E. Apt. #32 Washington, D.C. 20019 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
National Harmony Memorial Park | | Date
5/19/99 | | 20c. Location - City or Town, State
Landover, Maryland | |
| | 21. Signature of Funeral Service Licensee
<i>Alley J. Vallain</i> | | | | 22. Name and Address of Facility
Rollins Funeral Home, Inc.
4339 Hunt Place, N.E. Washington, D.C. 20019 | | | |
| | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death)
e. <i>CARDIOVASCULAR ARREST</i>
Due to (or as a consequence of):
b. <i>PROBABLE PULMONARY EMBOLISM</i>
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>END STAGE RENAL DISEASE</i>
<i>MORBID OBESITY</i> | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown

24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and Title of Certifier
<i>Attending Physician</i> | | 29c. License number
D42749 | | 29d. Date signed (Month, Day, Year)
5/14/99 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
RAYMOND NWADIUKO, MD 9831 GREENBELT RD, STE 101 LANHAM MD 20706 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 21 1999 | | 32. Registrar's Signature
<i>James A. Smith</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17942

| | | | | | | | |
|--|--|---|---|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Betty Sue McGriff | | | | 2. Date of Death
Month Day Year
MAY 11 1999 | | 3. Time of Death
0801 |
| | 4a. Facility Name (If not institution, give street and number)
4917 TEMPLE HILLS ROAD | | | | 4b. City, Town, or Location of Death
TEMPLE HILLS | | 4c. County of Death
PRINCE GEORGES |
| Funeral
Director | 5. Social Security Number
578-64-8731 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
50 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
8/12/48 | 9. Birthplace (State or Foreign Country)
NORTH CARO. |
| | Usual Residence of Decedent | | | | | | |
| 10a. State
MD | | 10b. County
Prince Georges | | 10c. City, Town or Location
Temple Hills | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number
4917 Temple Hills Road | | | | 10f. Zip Code
20748 | | 10g. Citizen of What Country?
United States | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Correction Officer | | 16b. Kind of Business/Industry
Private | |
| 17. Father's Name (First, Middle, Last)
Clarence Crossland | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lillie Mae Swiney | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Cortney Marshall/SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P. O. Box 3002, Hyattsville, MD 20784 | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glenwood Cemetery | | Date
5-15-99 | | 20c. Location - City or Town, State
Washington, DC | |
| 21. Signature of Funeral Service Licensee
Edward M. Dudley | | | | 22. Name and Address of Facility
Dudley Funeral Home
3200 Rhode Island Ave., Mt. Rainier, MD 20712 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CANCER OF UTERUS WITH METASTASIS
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | 24e. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier
[Signature] | | | | 29c. License number
D 33954 | | 29d. Date signed (Month, Day, Year)
MAY 11, 1999 | |
| 30. Name and address of person who completed cause of death (Item 27a) (Type, Print)
MARIO F. GOLLE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785 | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1999 | | | | 32. Registrar's Signature
[Signature] | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17943

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lester Miller, Jr.

2. Date of Death

Month
MAY

Day

17

Year

1999

3. Time of Death

2214

4a. Facility Name (If not institution, give street and number)

Union Hospital

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

222-20-0950

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

November

30,

1937

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Md.

10b. County

Cecil

10c. City, Town or Location

Rising Sun

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

45 Patrick Ward Drive

10f. Zip Code

21911

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
3

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self employed contractor

16b. Kind of Business/Industry

Trucking

17. Father's Name (First, Middle, Last)

Lester Miller

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Green

19a. Informant's Name/Relationship (Type, Print)

Cynthia Osborne, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

28 Pinder Ave., Elkton, Md. 21921

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Union Cemetery

Date

5/22/99

20c. Location - City or Town, State

Elkton, Md.

21. Signature of Funeral Service Licensee

Edward J. K...
Gee Funeral Home

22. Name and Address of Facility

259 E. Main St.,
Elkton, Md. 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

Years

c. Hypertension

Due to (or as a consequence of):

Years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W. J. M.P.

29c. License number

D0047711

29d. Date signed (Month, Day, Year)

May 17, 1999

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

DAVID GAR-EL 3 MAULDIN AVENUE NORTH EAST MARYLAND 21901

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

By the Court of the County of ...
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17944

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen G. McIver

2. Date of Death

Month Day Year
5 23 99

3. Time of Death

8:30 am

4a. Facility Name (If not Institution, give street and number)

Calvert Manor Healthcare Center

4b. City, Town, or Location of Death

Rising Sun

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

179-22-4510

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
2/5/18

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Cecil

10c. City, Town or Location

Rising Sun

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1881 Telegraph Road

10f. Zip Code

21911

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

secretary

16b. Kind of Business/Industry

education

17. Father's Name (First, Middle, Last)

William Humes

18. Mother's Name (First, Middle, Maiden Summa)

Ada Evans

19a. Informant's Name/Relationship (Type, Print)

Joan M. Teeter daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

203 Fifth Street Road, Oxford, PA 19363

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oxford Cemetery

Date

5/27/99

20c. Location - City or Town, State

Oxford, PA

21. Signature of Funeral Service Licensee

Kevin D. Collins

22. Name and Address of Facility

Collins Funeral Home
86 Pine Street, Oxford, PA 19363

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

A.S.C.V.D

b. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 wk.

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. R. Taylor MD

29c. License number

0-11115

29d. Date signed (Month, Day, Year)

May 23rd 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Neil R. Taylor Jr. MD Calvert Health Care Center Rising Sun, MD 21911

31. Date filed (Month, Day, Year)

MAY 25 1999

32. Registrar's Signature

Brenda B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17965

| | | | | | | | | |
|--|--|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MAGGIE McBROOM | | | | 2. Date of Death
Month 05 Day 19 Year 99 | | 3. Time of Death
6:35 am | |
| | 4a. Facility Name (If not institution, give street and number)
Manor Care Health Center | | | | 4b. City, Town, or Location of Death
Largo | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
244-42-5611 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
85 Yrs. | | 8. Date of Birth (Month, Day, Year)
September 17, 1913 | |
| | 9. Birthplace (State or Foreign Country)
North Carolina | | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Capitol Heights | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number
5510 Highmount Lane | | 10f. Zip Code
20743 | |
| | 10g. Citizen of What Country?
U.S.A. | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
11th | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laundry Technician | | | | 16b. Kind of Business/Industry
Private | | | |
| | 17. Father's Name (First, Middle, Last)
Samuel Jones | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Nancy Pratt | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Betty J. Miller/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5510 Highmount Lane, Capitol Heights, Maryland 20743 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Church Cemetery | | 20c. Location - City or Town, State
Hillsborough, N.C. | |
| | 21. Signature of Funeral Service Licensee
<i>Belma J. Jenkins</i> | | | | 22. Name and Address of Facility
J.B. JENKINS FUNERAL HOME
7474 Landover Road, Landover, Maryland 20785 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac arrest
Due to (or as a consequence of):
b. Hypertension
Due to (or as a consequence of):
c. Atrial fibrillation
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death
minutes
yrs
yrs | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how Injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
<i>James Kim, M.D.</i> | | 29c. License number
016191 | | |
| 29d. Data signed (Month, Day, Year)
5/19/99 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
10694 Campus Way S. Capd, MD 20774 James Kim, M.D. | | | | |
| 31. Date filed (Month, Day, Year)
MAY 20 1999 | | | | 32. Registrar's Signature
<i>James Kim</i> | | | | |

Baltimore, Maryland 21215-0020

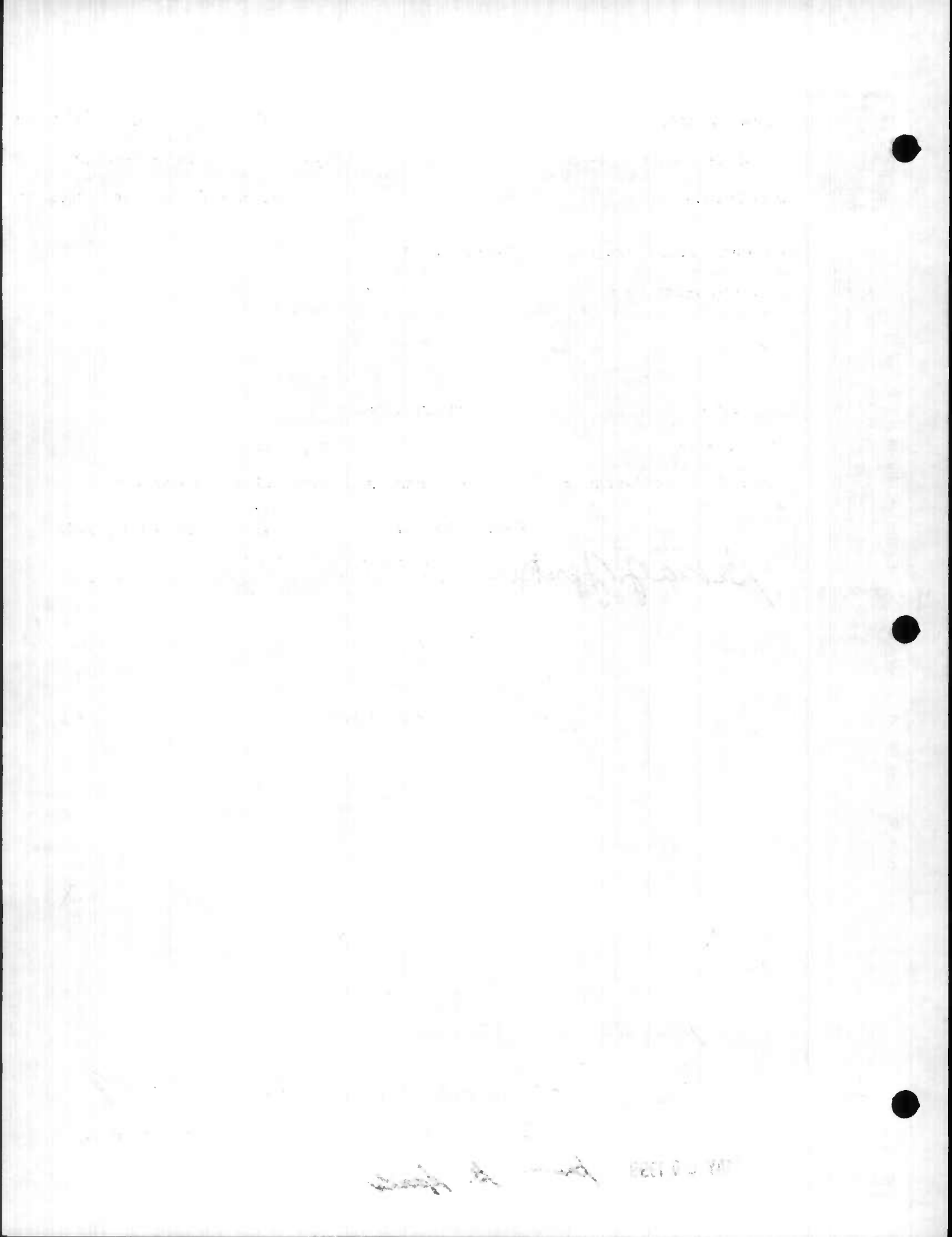
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17946

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT MARTIN

2. Date of Death

Month

Day

Year

05 - 19 - 1999

11:10AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

HEARTLAND HEALTH CARE CENTER

4b. City, Town, or Location of Death

HYATTSVILLE

4c. County of Death

PRINCE GEORGE

5. Social Security Number

579-76-3485

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

41 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

6-16-57

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

WASHINGTON, DC

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

213 ROCK CREEK CHURCH RD

10f. Zip Code

20011

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

GED

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CARPENTER

16b. Kind of Business/Industry

SELF EMPLOYED

17. Father's Name (First, Middle, Last)

ART NATHANIEL MARTIN

18. Mother's Name (First, Middle, Maiden Surname)

VIRGINIA ELIZABETH CARY

19a. Informant's Name/Relationship (Type, Print)

VIRGINIA MARTIN, MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

213 ROCK CREEK CHURCH RD NW WASH. DC 20011

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Forest Hills Cemetery

Date

5/24/99

20c. Location - City or Town, State

CLINTON, MD

21. Signature of Funeral Service Licensee

Donna S. [Signature] MD1188

22. Name and Address of Facility

W. H. BACON FUNERAL HOME
3447 14TH ST NW WASHINGTON DC 20010

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CARDIO RESPIRATORY FAILURE

Approximate Interval Between Onset and Death

Due to (or as a consequence of):

AIDS

Due to (or as a consequence of):

ANOXIC ENCEPHALOPATHY

Due to (or as a consequence of):

SEIZURE

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

NA

28b. Time of Injury

NA M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

NA

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

NA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

NA

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

D42019

29d. Date signed (Month, Day, Year)

05-19-1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WIRAN CHOWDHURY 7350 VAN DUSEN RD
LAUREL MD 20707

31. Date filed (Month, Day, Year)

MAY 21 1999

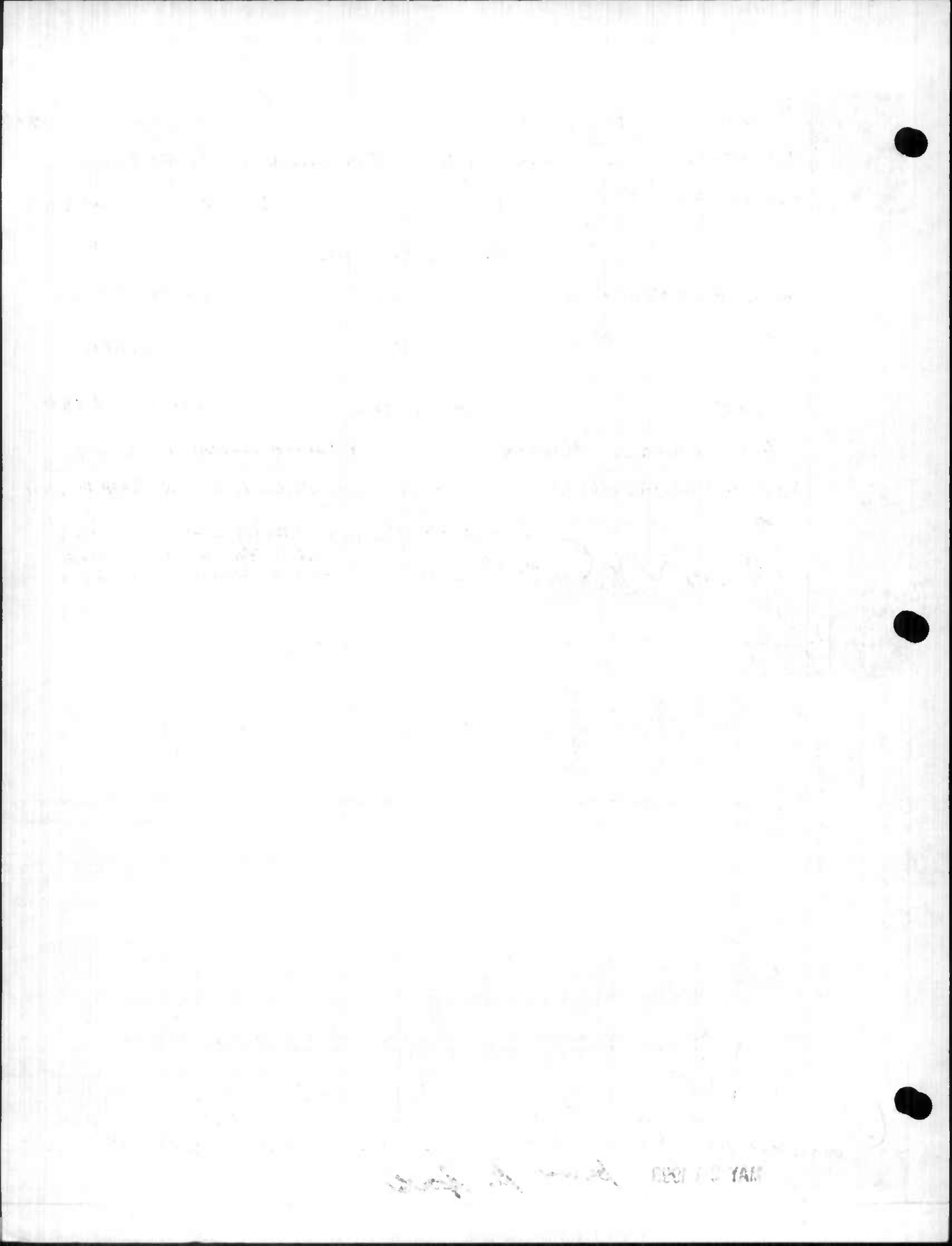
32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17967

| | | | | | | | | |
|---|--|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Thomas McColl | | | | 2. Date of Death
Month Day Year
May 18, 1999 | | 3. Time of Death
3:10 p.m. | |
| | 4a. Facility Name (If not institution, give street and number)
Mariner Health of Southern Maryland | | | | 4b. City, Town, or Location of Death
Clinton | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
248 18 4192 | | 6. Sex
15 M 2 F | | 7. Age (In yrs. last birthday)
84 | | 8. Date of Birth (Month, Day, Year)
September 3, 1914 | |
| | 9. Birthplace (State or Foreign Country)
South Carolina | | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Clinton | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 X Yes 2 No | | 10e. Street and Number
9211 Stuart Lane | | 10f. Zip Code
20735 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 Never Married 2 Married 3 Widowed 4 X Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
1 Yes 2 X No | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Cook | | 16b. Kind of Business/Industry
Government | | 17. Father's Name (First, Middle, Last)
Unknown | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Hattie McColl | | 19a. Informant's Name/Relationship (Type, Print)
Timothy McColl/son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
907 Postwick Place Bowie, MD 20716 | | 20a. Method of Disposition
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Forest Hills Cemetery | | 20c. Date
5-22 | | 20d. Location - City or Town, State
Clinton, Maryland | | 21. Signature of Funeral Service Licensee
Kimberly C. Buscoe-Tomic | |
| | 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MD 4308 Suitland Road Suitland, MD 20746 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
CONGESTIVE HEART FAILURE | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 X Unknown | | 23c. Approximate Interval Between Onset and Death | |
| To Be Completed by Physician/Medical Examiner | 23d. Immediate Cause (Final disease or condition resulting in death)
HYPERTENSION | | 23e. Due to (or as a consequence of): | | 23f. Due to (or as a consequence of): | | 23g. Due to (or as a consequence of): | |
| | 23h. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | 23i. Due to (or as a consequence of): | | 23j. Due to (or as a consequence of): | | 23k. Due to (or as a consequence of): | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. Was an autopsy performed?
1 Yes 2 X No | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No | | | | 25. Was case referred to medical examiner?
1 Yes 2 X No | | | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 X Nursing Home 5 Residence 8 Other (Specify) | | 27. Manner of Death
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| | 28c. Injury at Work?
1 Yes 2 No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and Title of certifier
[Signature] MD | | 29c. License number
753885 | | 29d. Date signed (Month, Day, Year)
5/20/99 | |
| | 29e. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W. VENKAT. S. RAMANAN 7501 SURRATTS ROAD #307 CLINTON MD 20735 | | 31. Date filed (Month, Day, Year)
MAY 21 1999 | | 32. Registrar's Signature
[Signature] | |

August 2, 1962

Dear Mr. [illegible]

I am writing you to [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

Very truly yours,
[illegible signature]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17968

| | | | | | | | | |
|--|--|--|---|---|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Joseph Patrick Mackie | | | | 2. Date of Death
Month MAY Day 14 Year 1999 | | 3. Time of Death
2345 | |
| | 4a. Facility Name (If not Institution, give street and number)
7305 GAVIN STREET | | | | 4b. City, Town, or Location of Death
NEW CARROLLTON | | 4c. County of Death
PRINCE GEORGES | |
| Funeral
Director | 5. Social Security Number
578-12-0610 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
79 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sept. 5, 1919 | 9. Birthplace (State or Foreign Country)
Washington, DC |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Hyattsville | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
4902 West Lanham Drive | | | | 10f. Zip Code
20784 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Supervisor | | | 16b. Kind of Business/Industry
Washington Gas & Light Company | |
| 17. Father's Name (First, Middle, Last)
Robert Mackie | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lillie Van Reswyck | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Michael R. Mackie - Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
714 Ridge Drive, McLean, Virginia 22101 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery | | Date
05/18/99 | | 20c. Location - City or Town, State
Brentwood, Maryland | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Gasch's Funeral Home
4739 Baltimore Avenue, Hyattsville, MD 20781 | | | | |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE
Due to (or as a consequence of):

x AND DIABETES MELLITUS
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Friends Residence | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner | | 29b. Signature and Title of certifier
 | | | | | | |
| | | 29c. License number
0339574 | | 29d. Date signed (Month, Day, Year)
MAY 16, 1999 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
MARIO F. GOLUE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 18 1999 | | 32. Registrar's Signature
 | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

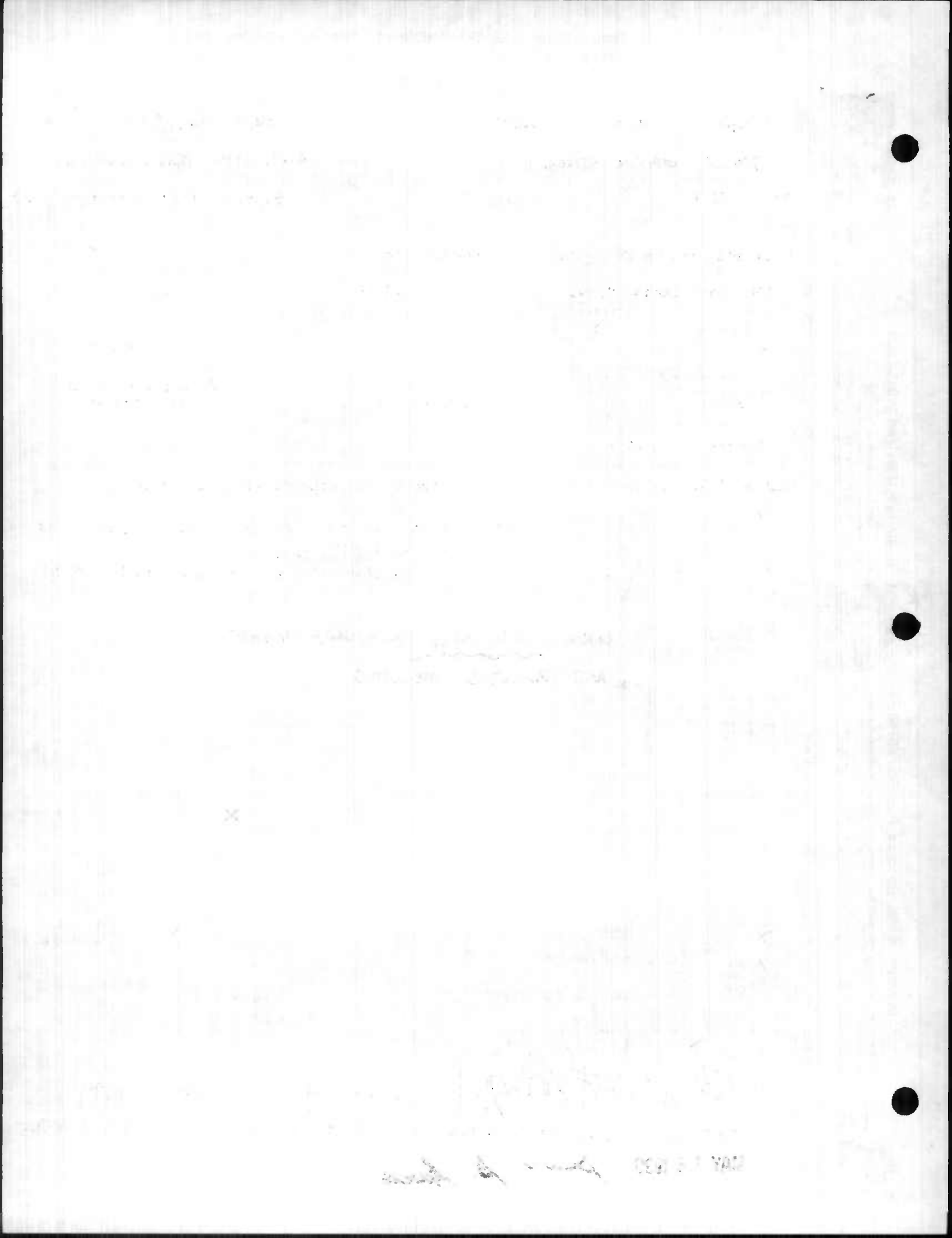
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Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



AVAN

McClearn

99 17949

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Avan McClearn

2. Date of Death

Month
MAY

Day

16, 1999

Year

3. Time of Death

5:15P.M.

4a. Facility Name (If not institution, give street and number)

2716 SANSBURY ROAD

4b. City, Town, or Location of Death

UPPER MARLBORO

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

219-72-3613

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

39 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

Sept. 22, 1959

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2716 Sansbury Rd.

10f. Zip Code

20774

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 11/6/79

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Postal Worker

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Thomas McClearn

18. Mother's Name (First, Middle, Maiden Surname)

Christine Penny

19a. Informant's Name/Relationship (Type, Print)

Christine McClearn/ Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2716 Sansbury Rd. Upper Marlboro, Md. 20774

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Washington National Cem.

Date

5/22/99

20c. Location - City or Town, State

Suitland, Md.

21. Signature of Funeral Service Licensee

Keith G. Savage

22. Name and Address of Facility

Alexander S. Pope Funeral Homes

5538 Marlboro Pike/Forestville, Maryland 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Stab and Cutting Wounds

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☒ Homicide

28a. Date of Injury (Month, Day, Year)

May 16, 1998

28b. Time of Injury

5:10 P.M.

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject was stabbed & cut
28f. Location (Street and Number or Rural Route Number, City or Town, State) 2716 Sansbury Road
Upper Marlboro, Maryland

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

REAR YARD of residence

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen S. Radentz, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

MAY 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radentz

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 18 1999

Registrar's Signature

James B. Davis

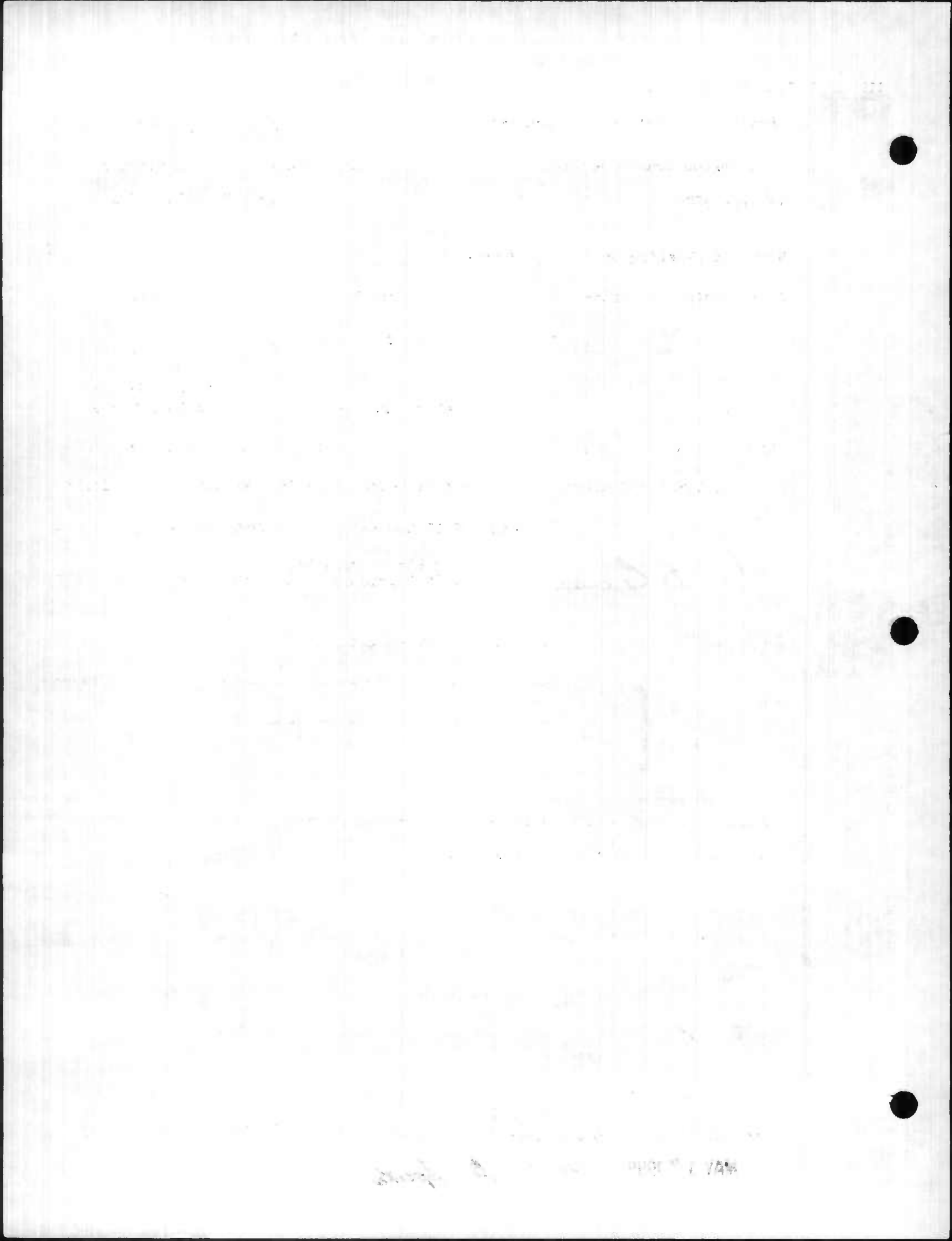
State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 17951

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|-------------------------------------|--|--|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Kathleen Blankenship McGee | | | | 2. Date of Death
Month Day Year
April 29, 1999 | | | | 3. Time of Death
2:55 PM | |
| | 4a. Facility Name (If not institution, give street and number)
18265 Oakland Avenue | | | | 4b. City, Town, or Location of Death
Valley Lee | | | | 4c. County of Death
St. Mary's | |
| Funeral
Director | 5. Social Security Number
226-12-8312 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
83 Yrs. | | 8. Date of Birth (Month, Day, Year)
December 6, 1915 | | 9. Birthplace (State or Foreign Country)
Virginia | |
| | Usual Residence of Decedent | | | | 10a. State
Maryland | | 10b. County
St. Mary's | | 10c. City, Town or Location
Valley Lee | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
18265 Oakland Avenue | | | | 10f. Zip Code
20692 | |
| | 10g. Citizen of What Country?
United States | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Beautician | | | | 16b. Kind of Business/Industry
Cosmetology | | | | 17. Father's Name (First, Middle, Last)
Andrew George Blankenship | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Mattie Booker McCormick | | | | 19a. Informant's Name/Relationship (Type, Print)
Diana Pessagno, Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
18265 Oakland Avenue, Valley Lee, Maryland 20692 | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery | | | | 20c. Location - City or Town, State
5/3/99 Brentwood, MD | |
| | 21. Signature of Funeral Service Licensee

Edward N. Brinsfield, Jr. M00052 | | | | 22. Name and Address of Facility
Brinsfield Funeral Home, P.A.
22955 Hollywood Road, Leonardtown, MD 20650 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Stroke
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury
M | | | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| Physician
/Medical
Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier

Edward N. Brinsfield, Jr. | | | | 29c. License number
1734197 | |
| | 29d. Date signed (Month, Day, Year)
4/30/99 | | | | 30. Name and address of person who completed cause of death (from 23e) (Type, Print)
24035 Northcrest Holly wood me | | | | 31. Date filed (Month, Day, Year)
MAY 03 1999 | |
| | 32. Registrar's Signature

Sparks | | | | 33. State Registrar
State Registrar | | | | 34. DHMH 16 Rev 6/95 | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17952

| | | | | | | | | | | | | | | |
|---|--|--|---|---|---|--|--|---|---|-------------------------------------|--|-------------------------------|----------|----------|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Carroll Ralph Mattingly | | | | 2. Date of Death
Month Day Year
May 9, 1999 | | 3. Time of Death
11:07 AM | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
24631 Blackistone Road | | | | 4b. City, Town, or Location of Death
Hollywood | | 4c. County of Death
St. Mary's | | | | | | | |
| Funeral
Director | 5. Social Security Number
578-03-7752 | | 6. Sex
1 <input type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
84 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 6, 1915 | | | | | | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
St. Mary's | | 10c. City, Town or Location
Hollywood | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | |
| 10e. State
Maryland | | | 10f. Zip Code
20636 | | | 10g. Citizen of What Country?
U.S.A. | | | | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Building Contractor | | | 16b. Kind of Business/Industry
Construction | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
Carroll Hubert Mattingly | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Edwardina Mattingly | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Alice Mattingly/Spouse | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
24240 Windy Court, Hollywood, Maryland 20636 | | | | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Charles Memorial Gardens | | 20c. Location - City or Town, State
Leonardtown, Maryland | | 20d. Date
5/12/99 | | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 | | | | | | | | | | |
| 23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Due to (or as a consequence of):
 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. <u>Carcinoma of the Prostate</u></td> <td rowspan="4">Approximate Interval Between Onset and Death
YRS
YRS</td> </tr> <tr> <td>b. <u>Parkinson's disease</u></td> </tr> <tr> <td>c. _____</td> </tr> <tr> <td>d. _____</td> </tr> </table> | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <u>Carcinoma of the Prostate</u> | Approximate Interval Between Onset and Death
YRS
YRS | b. <u>Parkinson's disease</u> | c. _____ | d. _____ |
| Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <u>Carcinoma of the Prostate</u> | Approximate Interval Between Onset and Death
YRS
YRS | | | | | | | | | | | | |
| | b. <u>Parkinson's disease</u> | | | | | | | | | | | | | |
| | c. _____ | | | | | | | | | | | | | |
| | d. _____ | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| | | | 28d. Describe how injury occurred | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier
 | | | 29c. License number
D14285 | | 29d. Date signed (Month, Day, Year)
5-10-99. | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
William Boyd, II, MD Leonardtown, Maryland 20650 | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 10 1999 | | | 32. Registrar's Signature
 | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17953

| | | | | | | | | | | |
|--|---|---|--|---|---|---------------------------------|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Rebecca F. Moore</u> | | | | 2. Date of Death
Month <u>May</u> Day <u>23</u> Year <u>1999</u> | | | | 3. Time of Death
<u>10:37 Am</u> | |
| | 4a. Facility Name (If not institution, give street and number)
<u>Howard County General Hospital</u> | | | | 4b. City, Town, or Location of Death
<u>Columbia</u> | | | | 4c. County of Death
<u>Howard</u> | |
| Funeral
Director | 5. Social Security Number
<u>219-38-6860</u> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<u>84</u> Yrs. | | 8. Date of Birth (Month, Day, Year)
<u>August 9, 1914</u> | | 9. Birthplace (State or Foreign Country)
<u>Maryland</u> | |
| | Usual Residence of Decedent | | | | 10a. State
<u>Maryland</u> | | 10b. County
<u>Howard</u> | | 10c. City, Town or Location
<u>Jessup</u> | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
<u>9941 Guilford Road</u> | | | | 10f. Zip Code
<u>20794</u> | | 10g. Citizen of What Country?
<u>United States</u> | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: <u>Black</u> | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>10</u> College (1-4 or 5+) <u></u> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Homemaker</u> | | | | 16b. Kind of Business/Industry
<u>N/A</u> | | |
| 17. Father's Name (First, Middle, Last)
<u>Robert Aubrey Bennett</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Mary Catherine Lee</u> | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<u>Loretta Ann Lane, Daughter</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>9987 Guilford Road, Jessup, Maryland 20794</u> | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>St. Peter Claver Cemetery</u> | | | | 20c. Location - City or Town, State
<u>5-29-99 St. Inigoes, Maryland</u> | | |
| 21. Signature of Funeral Service Licensee
<u>Mary B. Rizzo, MD1114</u> | | | | 22. Name and Address of Facility
<u>Brinsfield Funeral Home, P.A.</u>
<u>22955 Hollywood Rd., Leonardtown, MD 20650-0279</u> | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one disease on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <u>myocardial infarction</u>
Due to (or as a consequence of):
b. <u>coronary artery disease</u>
Due to (or as a consequence of):
c. <u></u>
Due to (or as a consequence of):
d. <u></u>

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>CHF, atrial fibrillation, ischemic -</u>
<u>cardiomyopathy</u> | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
<u>M</u> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
<u>Jacob Ch...</u> MD | | | | 29c. License number
<u>DS0973</u> | | |
| 29d. Date signed (Month, Day, Year)
<u>May 23, 1999</u> | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>JACOB CHERIAN Two Knoll North Dr. Columbia MD 21045</u> | | | | | | |
| 31. Date filed (Month, Day, Year)
<u>MAY 27 1999</u> | | | | 32. Registrar's Signature
<u>B. Sp...</u> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17954

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES W. MICKENS

2. Date of Death

Month Day Year
May 17 1999

3. Time of Death

05:43 AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-20-1261

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

8. Under 1 Year

Months Days

9. Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 11, 1922

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

13151 Cabinwood Drive

10f. Zip Code

20904

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1 yr.

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Exhibits Specialist

16b. Kind of Business/Industry

Smithsonian

17. Father's Name (First, Middle, Last)

William D. Mickens

18. Mother's Name (First, Middle, Maiden Surname)

Louise Mickens

19a. Informant's Name/Relationship (Type, Print)

Mary G. Mickens - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13151 Cabinwood Drive, Silver Spring, MD 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Memorial Cemetery 5-26-99 Suitland, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

J. P. Marshall

22. Name and Address of Facility Marshall's Funeral Home, Inc.

4308 Suitland Road, Suitland, MD 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 DAYS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

10 DAYS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. J. Payne MD

29c. License number

D45121

29d. Date signed (Month, Day, Year)

MAY 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRIAN F. REAGAN MD - 1500 Forest Glen Rd Silver Spring MD 20910

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

B. J. Payne

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17955

Physician
(Medical
Examiner)

1. Decedent's Name (First, Middle, Last)

Dale Allen Nelson

2. Date of Death

MAY 03, 1999

3. Time of Death

15:30 PM

4a. Facility Name (If not institution, give street and number)

ST. MARY'S HOSPITAL

4b. City, Town, or Location of Death

Leonardtown

4c. County of Death

ST. MARY'S

Funeral
Director

5. Social Security Number

216-25-7649

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

18 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

August 6, 1980

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Clements

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

23925 Pincushion Road

10f. Zip Code

20624

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Student

16b. Kind of Business/Industry

High School

17. Father's Name (First, Middle, Last)

David A. Nelson

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Guy

19a. Informant's Name/Relationship (Type, Print)

Dorothy Nelson/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 125, Clements, MD 20624

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Charles Memorial Gardens

Date

5/6/99

20c. Location - City or Town, State

Leonardtown, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, MD 2065023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☒ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

5/3/99

28b. Time of
Injury

1437M

28c. Injury at
Work?1 ☐ Yes 2 ☒ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

Street; Newtown Neck Rd + Rosebank Rd.; Leonardtown, Md

28d. Describe how injury occurred
Driver of motor vehicle
collided with another vehicle29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

MAY 04, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Pestaner

31. Date filed (Month, Day, Year)

MAY 05 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

ITEM#27 PER PHYNS G772 6-3-99 J.A.

17956

| | | | | | |
|---|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Baby Girl PARKER</i> | | 2. Date of Death
Month <i>April</i> Day <i>15</i> Year <i>1999</i> | | 3. Time of Death
<i>1827</i> |
| | 4a. Facility Name (If not institution, give street and number)
<i>THE JOHNS HOPKINS HOSPITAL</i> | | 4b. City, Town, or Location of Death
<i>BALTIMORE CITY</i> | | 4c. County of Death |
| Funeral
Director | 5. Social Security Number
<i>NONE</i> | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)
Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
<i>4-14-99</i> | | 9. Birthplace (State or Foreign Country)
<i>USA</i> | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10c. City, Town or Location
<i>Baltimore</i> | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. State
<i>MD</i> | 10b. County | | | |
| | 10f. Zip Code
<i>21231</i> | | 10g. Citizen of What Country?
<i>USA</i> | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: <i>BLACK</i> | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>0</i> College (1-4or 5+) <i>0</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>INFANT</i> | | 16b. Kind of Business/Industry
<i>INFANT</i> |
| | 17. Father's Name (First, Middle, Last)
<i>Unknown</i> | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Theresa Parker</i> | | |
| | 19e. Informant's Name/Relationship (Type, Print)
<i>Theresa Parker - mother</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>219 N. Dallas St - Baltimore, Md. 21231</i> | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <i>Disposal</i> | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Johns Hopkins Hospital</i> | | 20c. Location - City or Town, State
<i>Baltimore, Md.</i> |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | 22. Name and Address of Facility
<i>SHH-600 N. Wolfe St. 21287</i> | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death)
<i>Pulmonary Hypertension</i> | | | | <i>26 hours</i> |
| | Due to (or as a consequence of):
<i>Renal Anomalies</i> | | | | <i>26 hours</i> |
| | Due to (or as a consequence of):
<i>Prematurity</i> | | | | <i>26 hours</i> |
| | Due to (or as a consequence of):
<i>Cardiac Anomalies</i> | | | | <i>26 hours</i> |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Bilateral pneumothoraces with chest tubes</i>
<i>Complex Cardiac anomalies, cleft palate</i>
<i>Abnormal kidneys</i> | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
<i>[Signature] Resident</i> | | 29c. License number
<i>Res-000</i> | | 29d. Date signed (Month, Day, Year)
<i>April 15 1999</i> | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>MANAJI M. SUZUKI 600 North Wolfe Street Baltimore MD 21282</i> | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
<i>JUN 03 1999</i> | | 32. Registrar's Signature
<i>[Signature]</i> | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17957

| | | | | | | | | | | |
|---|--|---|--|---|--|--------------------------|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BETTY L. PAYNE | | | | 2. Date of Death
Month Day Year
MAY 11 1999 | | | | 3. Time of Death
11:57 am | |
| | 4a. Facility Name (If not institution, give street and number)
ANNE ARUNDEL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
ANNAPOLIS | | | | 4c. County of Death
ANNE ARUNDEL | |
| Funeral
Director | 5. Social Security Number
231-52-6666 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
59 Yrs. | | 8. Date of Birth (Month, Day, Year)
JAN. 20 1940 | | 9. Birthplace (State or Foreign Country)
VIRGINIA | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
ANNAPOLIS | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
3518 ROCKWAY AVENUE | | | | 10f. Zip Code
21403 | | | | 10g. Citizen of What Country?
US | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
NURSE AIDE | | | | 16b. Kind of Business/Industry
HERITAGE HALL NURSING HOME | | |
| 17. Father's Name (First, Middle, Last)
UNOBTAINABLE | | | | 18. Mother's Name (First, Middle, Maiden Surname)
PHYLLIS L. STILES | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
KARL PAYNE (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3518 ROCKWAY AVE. ANNAPOLIS, MD. 21403 | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
WHITE RIDGE CEMETERY | | | | 20c. Location - City or Town, State
5/18/99 EATONTOWN, N.J. | | |
| 21. Signature of Funeral Service Licensee
Harry D. Reese | | | | 22. Name and Address of Facility
WM REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. Septic Shock
Due to (or as a consequence of):</p> <p>b. Adult Respiratory Distress Syndrome
Due to (or as a consequence of):</p> <p>c. Peritonitis
Due to (or as a consequence of):</p> <p>d. Perforated Viscus
Due to (or as a consequence of):</p> </div> <div style="width: 15%; text-align: center;"> <p>72 weeks</p> <p>72 weeks</p> <p>72 weeks</p> <p>72 weeks</p> </div> </div> | | | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and Title of certifier
Michael | | | | 29c. License number
DM 35494 | | | | 29d. Date signed (Month, Day, Year)
5-14-99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Steven Resnick 64 Franklin Street Annapolis MD | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1999 | | | | 32. Registrar's Signature
B. Spindel | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17958

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Clarence Wade PIFER

2. Date of Death

Day Year

May 10, 1999

3. Time of Death

8:46 AM

4a. Facility Name (If not institution, give street and number)

Garrett County Memorial Hospital

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

5. Social Security Number

215-14-6733

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

3/28/1919

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Garrett

10c. City, Town or Location

Oakland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1744 Hutton Road

10f. Zip Code

21550

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Coal Miner

16b. Kind of Business/Industry

Coal Mining

17. Father's Name (First, Middle, Last)

Lewis Randolph Pifer

18. Mother's Name (First, Middle, Maiden Surname)

Emma Thomas

19a. Informant's Name/Relationship (Type, Print)

Clarence W. Pifer/ SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1744 Hutton Rd., Oakland, MD 21550

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ashby Cemetery

Date

5/14/99 Oakland, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stewart Funeral Home

32 S. Second St., Oakland, MD 21550

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Cardiogenic Shock

Due to (or as a consequence of):

1 day

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Myocardial Infarction

Due to (or as a consequence of):

1 day

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Flutter

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

H26154

29d. Date signed (Month, Day, Year)

5/10/99

30. Name and address of person who completed Cause of death (Item 23a) (Type, Print)

Dr. P. Daniel Miller, DO 69 Wolf Acres Drive, Oakland, Maryland 21550

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Emma Pusey

2. Date of Death

Month Day Year
May 21, 1999

3. Time of Death

10:50 p.m.

4a. Facility Name (If not institution, give street and number)

Edw. W. McCready Memorial Hospital

4b. City, Town, or Location of Death

Crisfield

4c. County of Death

Somerset

Funeral
Director

5. Social Security Number

225-14-3953

6. Sex

☐ M ☒ F

7. Age (in yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 5, 1913

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

PA.

10b. County

Chester

10c. City, Town or Location

West Grove

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

373 Avondale Rd.

10f. Zip Code

19390

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Navar Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collega (1-4or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teletype Operator

16b. Kind of Business/Industry

Pennsylvania Railroad

17. Father's Name (First, Middle, Last)

Jacob E Skidmore

18. Mother's Name (First, Middle, Maiden Surname)

Mabel Mister Skidmore

19a. Informant's Name/Relationship (Type, Print)

Leone S. Salyer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6327 Church St Chincoteague Va 23336

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Occahannock Crm.

Date

5-24-99

20c. Location - City or Town, State

Exmore Va.

21. Signature of Funeral Service Licensee

Constance Salyer Bailey Salyer Funeral Home 6327 Church St Chincoteague Va

22. Name and Address of Facility

Physician
/Medical
Examiner

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

16 DAYS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ASCVD

30 YRS.

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CAD.

COPD

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D51086

29d. Date signed (Month, Day, Year)

5-25-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. T. Kanchana, Main St., Crisfield, Md. 21817

State
Registrar

31. Date filed (Month, Day, Year)

MAY 25 1999

32. Registrar's Signature

B. Apant

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17960

Amend #26. Per Phys. PGC 5-18-99 cr

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BERNARD PERRY

2. Date of Death
Month Day Year

May 12, 1999

3. Time of Death

4:00 PM

4a. Facility Name (If not institution, give street and number)

Paint Branch Home

4b. City, Town, or Location of Death

Adelphi

4c. County of Death

Prince George's

5. Social Security Number

578-34-5689

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 6, 1930

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

403 Hillsboro Drive

10f. Zip Code

20902

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Accounting

17. Father's Name (First, Middle, Last)

Samuel Perry

18. Mother's Name (First, Middle, Maiden Surname)

Rebecca Regerty

19a. Informant's Name/Relationship (Type, Print)

Steve Perry, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14204 Oakvale Street, Rockville, Maryland 20853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

King David Memorial Garden

Date

5/16/1999

20c. Location - City or Town, State

Falls Church, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

STEIN HEBREW MEMORIAL FUNERAL HOME, INC.

232 CARROLL STREET, NW, WASHINGTON, DC 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. cardiac arrest
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. chronic obstructive lung disease
Due to (or as a consequence of):c. _____
Due to (or as a consequence of):d. _____
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's diseaseParkinsonismasthma / COPD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

241752

29d. Date signed (Month, Day, Year)

5/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bergit Schoellmann, MD, 10810 Connecticut Avenue, Kensington, MD 20895

31. Date filed (Month, Day, Year)

MAY 18 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

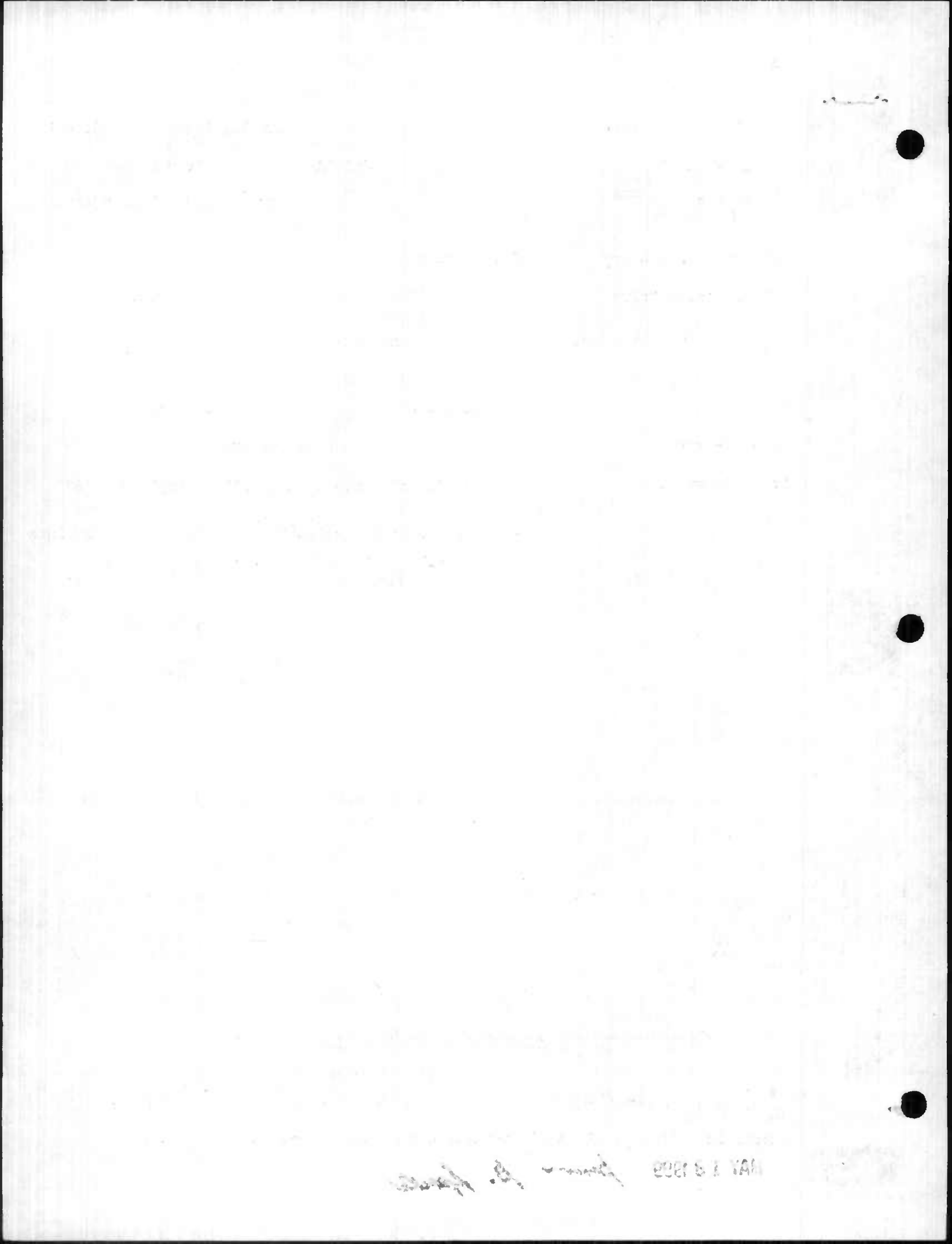
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

(12)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17961

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)
James F. Pringle | | | | 2. Date of Death
Month May Day 06 Year 99 | | 3. Time of Death
6:00 pm | |
| 4a. Facility Name (If not institution, give street and number)
Prince Georges Hospital | | | | 4b. City, Town, or Location of Death
Cheverly | | 4c. County of Death
Prince Georges | |
| 5. Social Security Number
238-78-3889 | | 6. Sex
2 M 2 F | 7. Age (In yrs. last birthday)
51 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
04/24/1948 | |
| 9. Birthplace (State or Foreign Country)
Brooklyn, NY | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State
DC | | 10b. County
Washington | | 10c. City, Town or Location
Washington | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number
900 Madison St. NW | | | | 10f. Zip Code
20011 | | 10g. Citizen of What Country?
United States | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Truck Driver/Landscape | | 16b. Kind of Business/Industry
Private | |
| 17. Father's Name (First, Middle, Last)
Franklin Pringle | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Annie Neely | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Betty Pringle Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
900 Madison St. NW, Washington, DC 20011 | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glenwood Cemetery | | Date
5/12/99 | | 20c. Location - City or Town, State
Washington, DC | |
| 21. Signature of Funeral Service Licensee
Edward M. Dudley | | | | 22. Name and Address of Facility
Dudley Funeral Home
3200 Rhode Island Ave., Mt. Rainier, MD | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Midbrain/Pontine hemorrhage
Due to (or as a consequence of):
b. Hypertension
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | Approximate Interval Between Onset and Death
hours
years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier
K. Michael Figaro | | | | 29c. License number
D0052865 | | 29d. Date signed (Month, Day, Year)
May 6th, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. K. Michael Figaro 3001 Hospital Dr., Cheverly, MD | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 18 1999 | | | | 32. Registrar's Signature
Bernie B. Smith | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 33a or 33a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the study and the objectives of the research.

2. The second part of the report is a detailed description of the methodology used in the study. It includes information about the sample size, the data collection methods, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes tables, figures, and text describing the findings of the research.

4. The fourth part of the report is a discussion of the results and their implications. It discusses the strengths and limitations of the study and provides suggestions for future research.

5. The fifth part of the report is a conclusion that summarizes the main findings of the study and provides a final statement on the importance of the research.

6. The sixth part of the report is a list of references that includes all the sources used in the study.

7. The seventh part of the report is an appendix that contains additional information that is not included in the main body of the report.

8. The eighth part of the report is a glossary that defines the key terms used in the study.

9. The ninth part of the report is a list of figures and tables that are included in the study.

Handwritten signature

Page 1 of 1

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17962

| | | | | | | | | | | |
|---|---|--|---|--|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Lucile C. Peterson | | | | | | 2. Date of Death
Month Day Year
5 20 1999 | | 3. Time of Death
9:45pm | |
| | 4a. Facility Name (If not institution, give street and number)
Calvert Manor | | | | | | 4b. City, Town, or Location of Death
Rising Sun | | 4c. County of Death
Cecil | |
| Funeral
Director | 5. Social Security Number
221-24-8291 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
90 Yrs. | | 8. Date of Birth (Month, Day, Year)
Jan. 30, 1909 | | 9. Birthplace (State or Foreign Country)
McCane, PA | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Cecil | | 10c. City, Town or Location
Rising Sun | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
1881 Telegraph Road | | | | 10f. Zip Code
21911 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
homemaker | | | | 16b. Kind of Business/Industry
own home | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Joseph McLaughlin | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ida Pfeffer | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
D. Thomas Peterson (son) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5 Headwater Lane Newark, DE 19711 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
All Saints Cem. | | 20c. Date
5/25/99 | | 20d. Location - City or Town, State
Wilmington, DE | | | |
| | 21. Signature of Funeral Service Licensee
<i>Nicholas D. Pistelli</i> | | 22. Name and Address of Facility
McCrery Funeral Homes, Inc.
3924 Concord Pike Wilm., DE 19803 | | | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Bronchopneumonia
Due to (or as a consequence of):
b. Chr Aspiration - 2° to Dementia
Due to (or as a consequence of):
c. Chr Diverticular Disease
Due to (or as a consequence of):
d. with Chr & I. Blood Loss | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dementia | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Jayantilal K Patel</i> | | 29c. License number
D 22 307 | | 29d. Date signed (Month, Day, Year)
5/21/99 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JAYANTILAL K PATEL, 123 Singendy Ave, Elkton, MD 21921 | | | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
MAY 24 1999 | | 32. Registrar's Signature
<i>B. Sparks</i> | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17963

| | | | | | | | | |
|--|--|---|--|--|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Jane Powell</u> | | | | 2. Date of Death
Month <u>05</u> Day <u>15</u> Year <u>1999</u> | | 3. Time of Death
<u>9:58 AM</u> | |
| | 4a. Facility Name (If not institution, give street and number)
<u>Prince George's Hospital Center</u> | | | | 4b. City, Town, or Location of Death
<u>Cheverly</u> | | 4c. County of Death
<u>Prince Georges</u> | |
| Funeral
Director | 5. Social Security Number
<u>579-28-4786</u> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>73</u> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<u>11-25-25</u> | 9. Birthplace (State or Foreign Country)
<u>Virginia</u> |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
<u>MD.</u> | | 10b. County
<u>Prince Georges</u> | | 10c. City, Town or Location
<u>Capitol Heights</u> | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
<u>211 West Mill Avenue</u> | | | | 10f. Zip Code
<u>20743</u> | | 10g. Citizen of What Country?
<u>U.S.A.</u> | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: <u>Black</u> | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12th</u> College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>DayCare Provider</u> | | | 16b. Kind of Business/Industry
<u>N/A</u> | |
| 17. Father's Name (First, Middle, Last)
<u>Byrm Grayson</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Dora Jackson</u> | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<u>Jefferson Powell/Husband</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>211- West Mill Ave., Capitol Hgts., Md. 20743</u> | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Fort Lincoln Cemetery</u> | | Date
<u>5/20/99</u> | | 20c. Location - City or Town, State
<u>Brentwood, Md.</u> | | |
| 21. Signature of Funeral Service Licensee
<u>Shelton W. Hackett</u> | | | | 22. Name and Address of Facility
<u>Bianchi Funeral Service
c/o Hackett's Funeral Chapel, Inc.
814- Upshur Street, N.W.</u> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<u>Asystolic cardiac arrest</u>
Due to (or as a consequence of):
<u>Acute myocardial infarction</u>
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Intracerebellar hemorrhage</u> | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and Title of certifier
<u>Isabelle Hertig, MD</u> | | 29c. License number
<u>D0054068</u> | | 29d. Date signed (Month, Day, Year)
<u>5/15/1999</u> | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<u>Isabelle HERTIG, MD. Prince George's Hospital.</u> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<u>MAY 18 1999</u> | | 32. Registrar's Signature
<u>Bernie B. Sparks</u> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17964

| | | | | | | | | | | |
|---|---|--|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ljudmila Petrovic | | | | 2. Date of Death
Month May Day 14 Year 1999 | | | | 3. Time of Death
7:40am | |
| | 4a. Facility Name (If not institution, give street and number)
Holy Cross Hospital | | | | 4b. City, Town, or Location of Death
Silver Spring | | | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
122-26-1200 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
78 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 25, 1920 | | 9. Birthplace (State or Foreign Country)
Lemnos, Greece | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by
Funeral Director | 10a. State
Md | | 10b. County
Montgomery | | 10c. City, Town or Location
Rockville | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number
12704 Veirs Mill Road | | | | 10f. Zip Code
20853 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Language Researcher | | | | 16b. Kind of Business/Industry
McGraw-Hill Publish | | | |
| To Be Completed by
Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Alexander Seniawin | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Helen Lebedva | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Ljudmila M. Petrovic/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12704 Veirs Mill Rd. #304 Rockville, Md | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Vladimir's Cem. | | Date
5/17/99 | | 20c. Location - City or Town, State
Jackson, N.J. | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
PHILIP D. RINALDI FUNERAL SERVICE
11818 New Hampshire Ave. Silver Spring, Md. | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Asystole
Due to (or as a consequence of):

b. Stroke
Due to (or as a consequence of):

c. Heart Attack
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death

unknown

unknown

unknown | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | | 24e. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| Medical Certification: To Be Completed by
Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28e. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Medical Examiner | | 29c. License number
DS0454 | | | | | | | |
| State
Registrar | 29b. Signature and title of certifier
 | | | | 29d. Date signed (Month, Day, Year)
May, 14, 1999 | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ARASTO HAZPORE MD 9801 Georgia Ave Silver Spring MD 20902 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 17 1999 | | | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

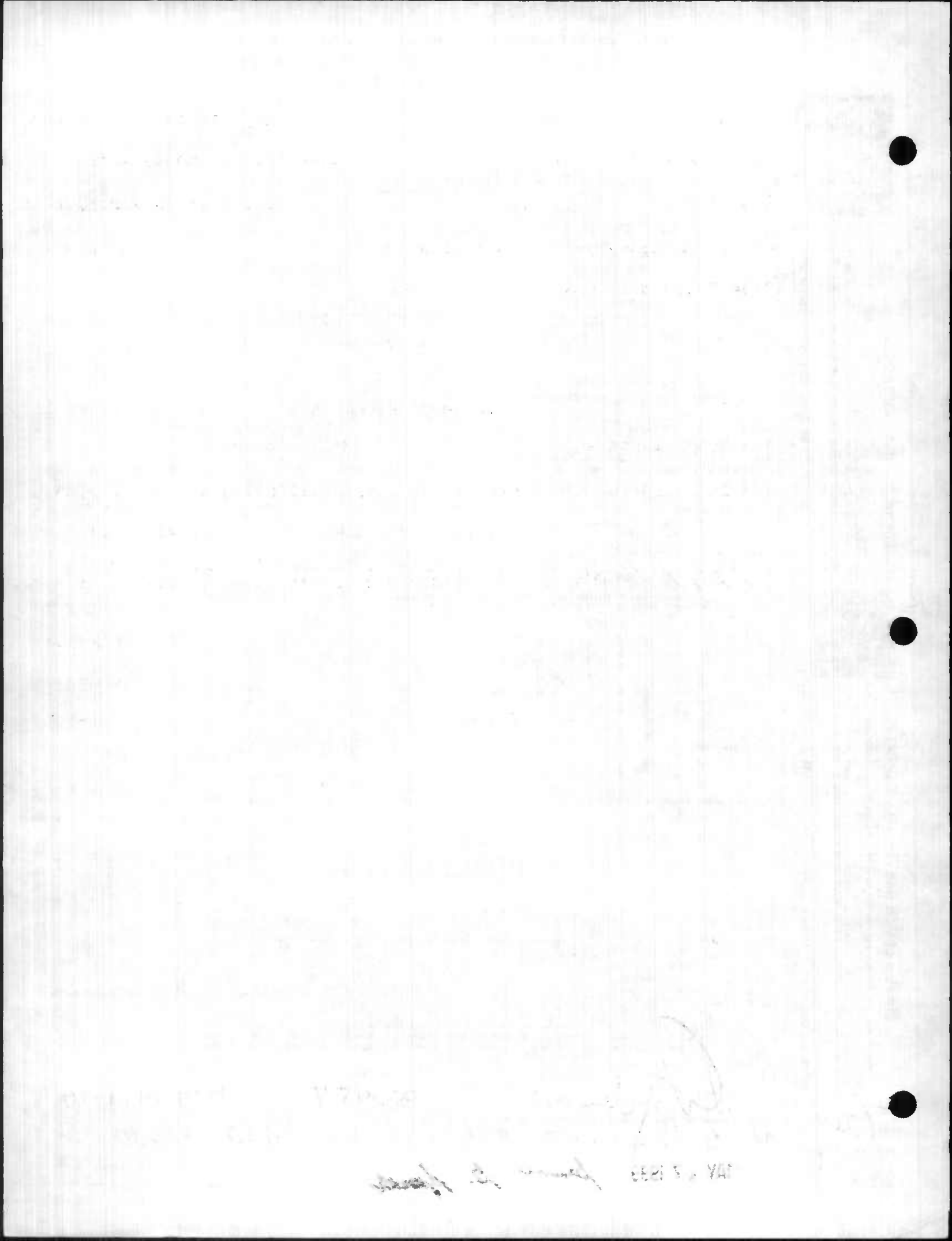
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

UNKNOWN 99-103

Robert Paul Paty

Certificate of Death

Reg. No.

99 17965

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-7 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | |
|--|---|---|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Robert Paul Paty | | | | 2. Date of Death
Month Day Year
MAY 13, 1999 | | 3. Time of Death
2230 PM | |
| | 4a. Facility Name (If not institution, give street and number)
FLORA CORNER ROAD | | | | 4b. City, Town, or Location of Death
MECHANICSVILLE | | 4c. County of Death
ST. MARY'S | |
| Funeral
Director | 5. Social Security Number
455-06-4500 | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
41 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
April 3, 1958 | | 9. Birthplace (State or Foreign Country)
Texas |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Calvert | | 10c. City, Town or Location
Lusby | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
246 Leason Cove Road | | | | 10f. Zip Code
20657 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Years | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Precision Target Program Manager | | | 16b. Kind of Business/Industry
U.S. Navy | |
| 17. Father's Name (First, Middle, Last)
Charles Kerwin Paty | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Rachel Perkins | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Sharon D. Paty/Spouse | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
246 Leason Cove Road, Lusby, Maryland 20657 | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Laurel Land Cemetery | | 20c. Location - City or Town, State
Dallas, Texas | | |
| 21. Signature of Funeral Service Licensee
Michael H. Hardin | | | | 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Multiple Injuries
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year)
5-13-99 | | 28b. Time of Injury
2:23 M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
Driver auto, fixed object collision |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Roadway | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Flora corner Rd | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
[Signature] | | | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
MAY 15, 1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1999 | | 32. Registrar's Signature
[Signature] | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17986

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Herbert Walter Pinkerton

2. Date of Death

MAY 16, 1999

3. Time of Death

11:15AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtown

4c. County of Death

St. Mary's

5. Social Security Number

194-20-8684

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 5, 1929

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

California

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

23151 Pine Bark Lane

10f. Zip Code

20619

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Navar Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1946-197213. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Noncommissioned Officer

16b. Kind of Business/Industry

Defense

17. Father's Name (First, Middle, Last)

Franklin Wesley Pinkerton

18. Mother's Name (First, Middle, Maiden Surname)

Martha Ann Knott

19a. Informant's Name/Relationship (Type, Print)

Margaret B. Pinkerton, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23151 Pine Bark Lane, California, Maryland 20619

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Charles Memorial Gardens

Date

5/19/99

20c. Location - City or Town, State

Leonardtown, Maryland

21. Signature of Funeral Service Licensee

Edward N. Brinsfield, Jr. M00052

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.
22955 Hollywood Road, Leonardtown, MD 2065023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Metastatic Carcinoma Prostate

one yr.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D33470

29d. Date signed (Month, Day, Year)

5/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. BHASKER A. JHAVERI HOLLYWOOD, MD. 20636

31. Date filed (Month, Day, Year)

MAY 18 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

NAME; HERBERT WALTER PINKERTON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99-17967

ITEM: #19B PER F.H. G772 6-2-99 WR.

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|--|--------------------------------|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HUGH DONALD POE | | | | 2. Date of Death
Month Day Year
MAY 16, 1999 | | 3. Time of Death
04:08 AM | |
| | 4a. Facility Name (If not institution, give street and number)
ST. JOSEPH HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
215-92-7047 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
32 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
6/15/1966 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD. | | 10b. County
Baltimore | | 10c. City, Town or Location
White Hall | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
20620 Green Road | | | | 10f. Zip Code
21161 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) - | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Mechanic | | 16b. Kind of Business/Industry
Automotive | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Hugh Melvin Poe | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Elizabeth Kathryn Rose | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Elizabeth A. Poe /Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
same as #10A,B,C,E,&F | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bel Air Mem. Gardens | | 20c. Location - City or Town, State
1999 Bel Air, Maryland | | | |
| | 21. Signature of Funeral Service Licensee
M. Gladden Ruff | | 22. Name and Address of Facility
E.G. Kurtz & Son Funeral Home, P.A.
Jarrettsville, Maryland | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| State Registrar | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
[Signature] | | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
MAY 16, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. LARON WATKINS, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | 32. Registrar's Signature
[Signature] | | | | | |
| | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 17968

ITEM: #19B PER F.H G772 6-2-99 WR.

Certificate of Death

Reg. No.

| | | | | | |
|---|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Annie Parrish | | 2. Date of Death
Month Day Year
April 21, 1999 | | 3. Time of Death
7:31 AM |
| | 4a. Facility Name (If not institution, give street and number)
Southern Maryland Hospital | | 4b. City, Town, or Location of Death
Clinton | | 4c. County of Death
Prince George's |
| Funeral
Director | 5. Social Security Number
224 72 3938 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
54 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
May 16, 1944 | | 9. Birthplace (State or Foreign Country)
Georgia | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State
VA | 10b. County
Prince William | 10c. City, Town or Location
Woodbridge | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
14032 Matthews Drive | | 10f. Zip Code
22191 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
minister | | 16b. Kind of Business/Industry
church | | |
| | 17. Father's Name (First, Middle, Last)
Thomas Newkirk | | 18. Mother's Name (First, Middle, Maiden Surname)
Ollie Smith | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Carolyn Cartledge daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
same as 10 14032 MATTHEWS DR. WOODBRIDGE VA. 22191 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mount Comfort Cem | | 20c. Location - City or Town, State
4/27/99 Alexandria VA |
| | 21. Signature of Funeral Service Licensee
John E. Greene | | 22. Name and Address of Facility
Greene Funeral Home Inc
814 Franklin St Alexandria VA 22314 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. Aspiration Pneumonia
Due to (or as a consequence of):
b. Endocarditis - Insulin Dependent Diabetes
Due to (or as a consequence of):
c. End Stage Renal Disease Dialysis Dependent
Due to (or as a consequence of):
d. CARDIO/respiratory Failure | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
Scott Kelso MD | | 29c. License number
D41580 | | 29d. Date signed (Month, Day, Year)
April 22, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
7503 SURREYS RD
CLINTON MD 20735 | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | 32. Registrar's Signature
B. Sparks | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

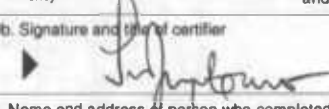
Certificate of Death

Reg. No.

99 17869

| | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | | 1. Decedent's Name (First, Middle, Last)
Harry Albert Robertson | | | | 2. Date of Death
Month May Day 24 , Year 1999 | | 3. Time of Death
04:17am | |
| | | 4a. Facility Name (If not institution, give street and number)
Memorial Hospital | | | | 4b. City, Town, or Location of Death
Cumberland | | 4c. County of Death
Allegany | |
| Funeral
Director | | 5. Social Security Number
220-10-4027 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
86 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 24, 1913 | |
| | | 9. Birthplace (State or Foreign Country)
MD | | 10a. State
MD | | 10b. County
Allegany | | 10c. City, Town or Location
Cumberland | |
| To Be Completed by Funeral Director | | 10e. Street and Number
14239 Cunningham Drive-Glen Oaks | | | | 10f. Zip Code
21502 | | 10g. Citizen of What Country?
USA | |
| | | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | |
| To Be Completed by Physician/Medical Examiner | | 15. Decedent's Education (Specify only highest grade completed)
12 Elementary/Secondary (0-12) College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Owner/Operator | | 16b. Kind of Business/Industry
Robbie's Truck Service | | | |
| | | 17. Father's Name (First, Middle, Last)
Rolley E. Robertson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Annie P (Layton) | | | |
| To Be Completed by Physician/Medical Examiner | | 19a. Informant's Name/Relationship (Type, Print)
Robert C. Robertson | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14241 Cunningham Dri;Cumberland, MD 21502 | | | |
| | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Restlawn Memorial Gard5/27/ LaVale, MD | | 20c. Location - City or Town, State | | 20d. Date | |
| To Be Completed by Physician/Medical Examiner | | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Scarpelli Funeral Home P.A. Cumberland, Maryland 21502 | | | |
| | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
15 years | | | |
| To Be Completed by Physician/Medical Examiner | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitis, Hypertension | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | 24a. Were an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury et Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
033280 | | 29d. Date signed (Month, Day, Year)
May 24, 1999 | |
| | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Sunil K. Gupta M.D. 625 Kent Avenue Cumberland MD 21502 | | | | | | | |
| State Registrar | | 31. Date filed (Month, Day, Year)
MAY 24 1999 | | 32. Registrar's Signature
 | | | | | |

220-10-4027 Dr. Gupta

Robertson, Harry Albert

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND#20BJ CMH AACO HEALTH DEPT.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17970

| | | | | | | | | | |
|---|---|---|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARGIE E. RICHARDSON | | | | 2. Date of Death
Month Day Year
MAY 13 1999 | | 3. Time of Death
12:11 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
NORTH ARUNDEL HOSPITAL | | | | 4b. City, Town, or Location of Death
Glen Burnie | | 4c. County of Death
ANNE ARUNDEL | | |
| Funeral
Director | 5. Social Security Number
212-46-6420 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
53 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
AUG. 23 1945 | | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | | | |
| | 10a. State
MARYLAND | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
PASADENA | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
7839 WILLING COURT | | | | 10f. Zip Code
21122 | | 10g. Citizen of What Country?
US | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th Collega (1-4or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
NURSE ASSISTANT | | 16b. Kind of Business/Industry
NORTH ARUNDEL HOSPITAL | | |
| | 17. Father's Name (First, Middle, Last)
JAMES H. HENDERSON | | | | 18. Mother's Name (First, Middle, Maiden Summa)
HATTIE HEBRON | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
VALERIE HOWARD (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
342 HIGHLAND DR. APT. 203 GLEN BURNIE, MD. 21061 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ASBURY BROADNECK CEME. | | Data
5/19/99 | | 20c. Location - City or Town, State
ST. MARGARETS, MD | | |
| | 21. Signature of Funeral Service Licensee
Harry D. Reese | | | | 22. Name and Address of Facility
HALL U.M. CEMETERY PASADENA, MD
WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Shock
Due to (or as a consequence of):
b. Severe Metabolic Derangements
Due to (or as a consequence of):
c. Sepsis
Due to (or as a consequence of):

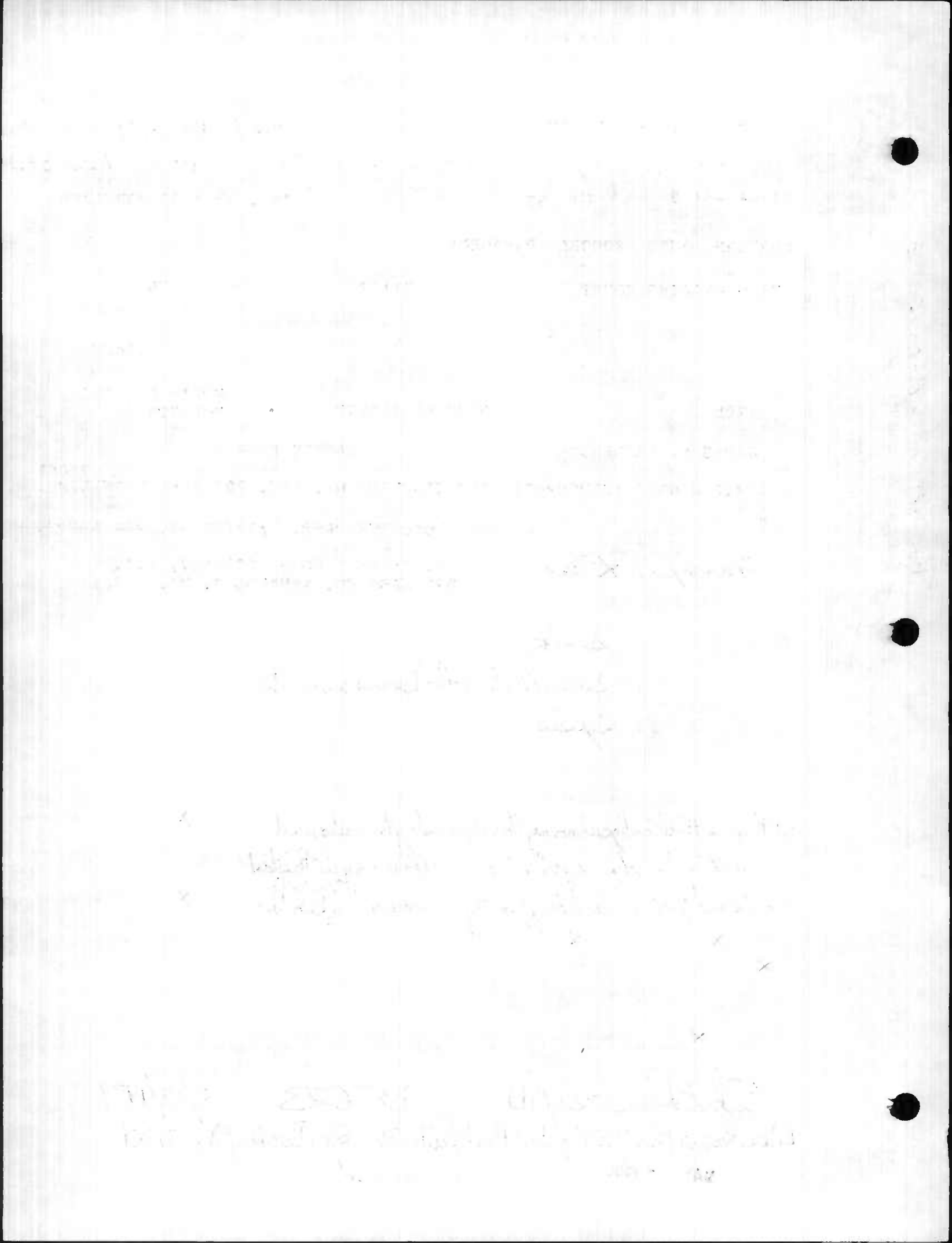
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
d. | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Recurrent Full Cardiac pulmonary threat, secondary to malignant ventricular dysrhythmias
Vancomycin Resistant Enterococcus of Bladder | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
Erik L. Russell MD | | | | 29c. License number
D43623 | | 29d. Date signed (Month, Day, Year)
5/13/1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Erik L. Russell M.D. 795 Aquahart Road, Suite 203, Glen Burnie, MD 21061 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1999 | | | | 32. Registrar's Signature
B. Apa | | | | | |

RICHARDSON - MARGIE E.
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

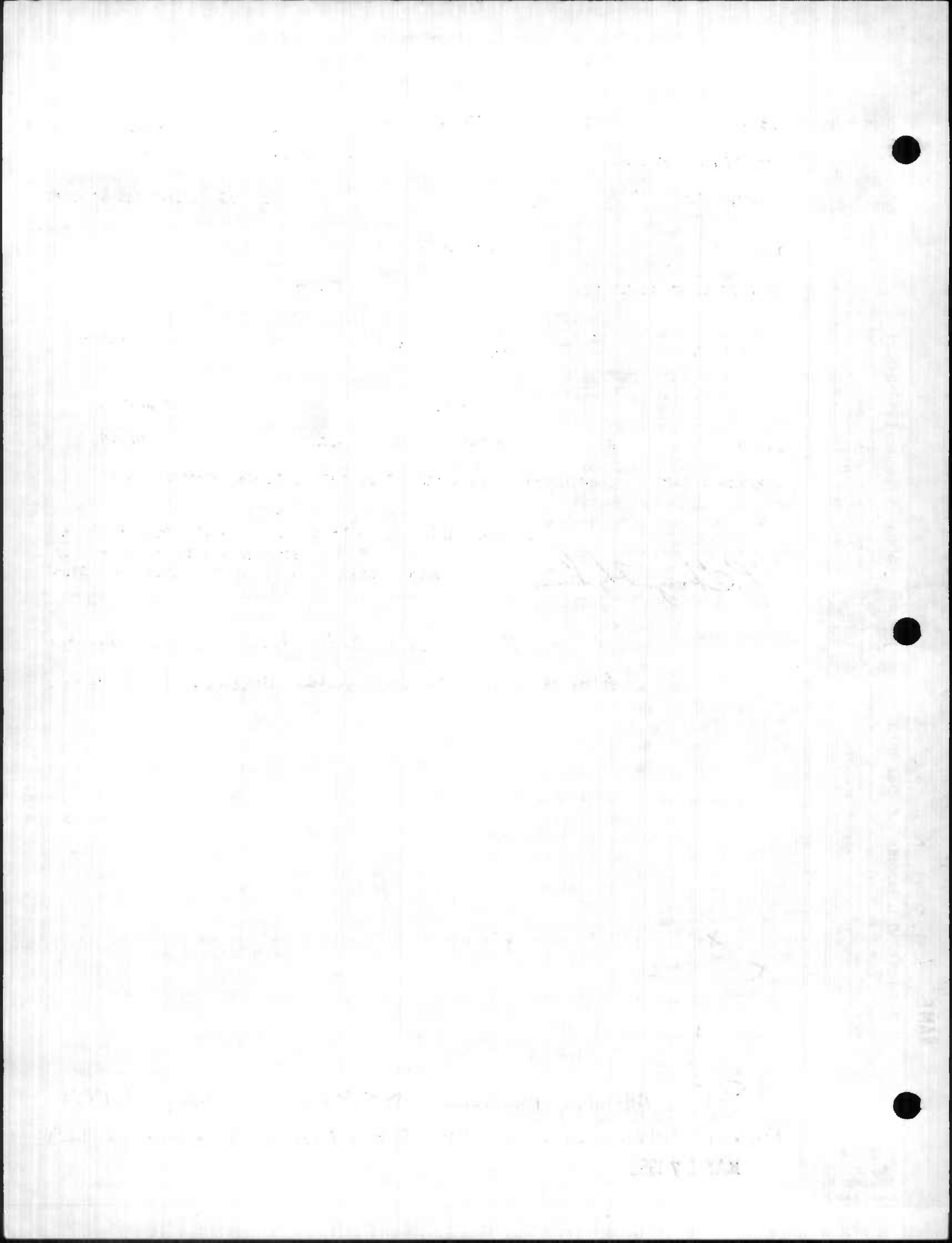


99 17971

| | | | | | | | | | | | | | | | |
|--|---|--|---|--|---|--|--|--|--|---|--|--|--------------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LYMAN ELMO RAINES, JR. | | | | | | 2. Date of Death
Month Day Year
MAY 14 1999 | | 3. Time of Death
12:27 PM | | | | | | |
| | 4a. Facility Name (If not institution, give street end number)
ST. AGNES HOSPITAL | | | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | | | | | | |
| Funeral
Director | 5. Social Security Number
236-48-0833 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
Yrs. 63 | | 8. Date of Birth (Month, Day, Year)
OCT. 13, 1935 | | 9. Birthplace (State or Foreign Country)
WEST VIRGINIA | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | | 10b. County | | 10c. City, Town or Location
BALTIMORE | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| | 10e. Street and Number
1002 CHESTNUT HAVEN CT. | | | | 10f. Zip Code
21226 | | 10g. Citizen of What Country?
U.S.A. | | | | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1954-
1959 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SALES | | 16b. Kind of Business/Industry
INDUSTRIAL | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
LYMAN E. RAINES, SR. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
BETTY COLLINS | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
THERESA ISAACS (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5914 SUNFLOWER DRIVE, COCOA, FLORIDA 32927 | | | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
FLORIDA MEMORIAL GARDENS | | Date
05/21 1999 | | 20c. Location - City or Town, State
ROCKLEDGE, FLORIDA | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SINGLETON FUNERAL HOME, P.A.,
1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | | | | | | | | |
| | 23e. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction
Due to (or as a consequence of):
b. Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | | | | Approximate Interval Between Onset and Death
Minutes
Unknown | | | | |
| | Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA | | Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 26. Place of Death (Check only one) | | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | 29b. Signature and title of certifier

Attending Physician | | 29c. License number
D51853 | | 29d. Date signed (Month, Day, Year)
May 14, 1999 |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael Silverman, MD 900 Caton Avenue Baltimore 21229 | | | | | | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
MAY 17 1999 | | 32. Registrar's Signature
 | | | | | | | | | | | | |



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 17972

AMEND # 26 AACO HEALTH DEPT CMH 5/18/99

Reg. No.

| | | | | | | | | | | |
|--|---|------------------------------------|---|---|--|--|--|---|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Eugenia E. Rehfeld | | | | | | 2. Date of Death
Month Day Year
May 15, 1999 | | 3. Time of Death
1:15 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
4890 Anchors Way | | | | | | 4b. City, Town, or Location of Death
Galesville | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
348-12-8781 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
93 Yrs. | | 8. Date of Birth (Month, Day, Year)
Jan. 5, 1906 | | 9. Birthplace (State or Foreign Country)
Wisconsin | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Edgewater | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10a. Street and Number
30 South River Road | | | | 10f. Zip Code
21037 | | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Home | | | |
| 17. Father's Name (First, Middle, Last)
Adam Weber | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Frances Lehrbraumer | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Shirley M. Fossum/ Daughter | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
30 South River Road Edgewater, MD 21037 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodfield Cemetery | | | Date
5-19-99 | | 20c. Location - City or Town, State
Galesville, Maryland | | |
| 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
George P. Kalas Funeral Home
2973 Solomons Island Rd. Edgewater, MD 21037 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. spinal cord infarction
Due to (or as a consequence of):

b. hypertension
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death
7 months

years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
cerebrovascular accident
aortic stenosis | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Daughters | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier
 | | | 29c. License number
045297 | | 29d. Date signed (Month, Day, Year)
5-17-99 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Elaine M Arata MD 104 Ridgely #201 Annapolis MD 2140 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 18 1999 | | | 32. Registrar's Signature
 | | | | | | | |

To Be Completed by Funeral Director

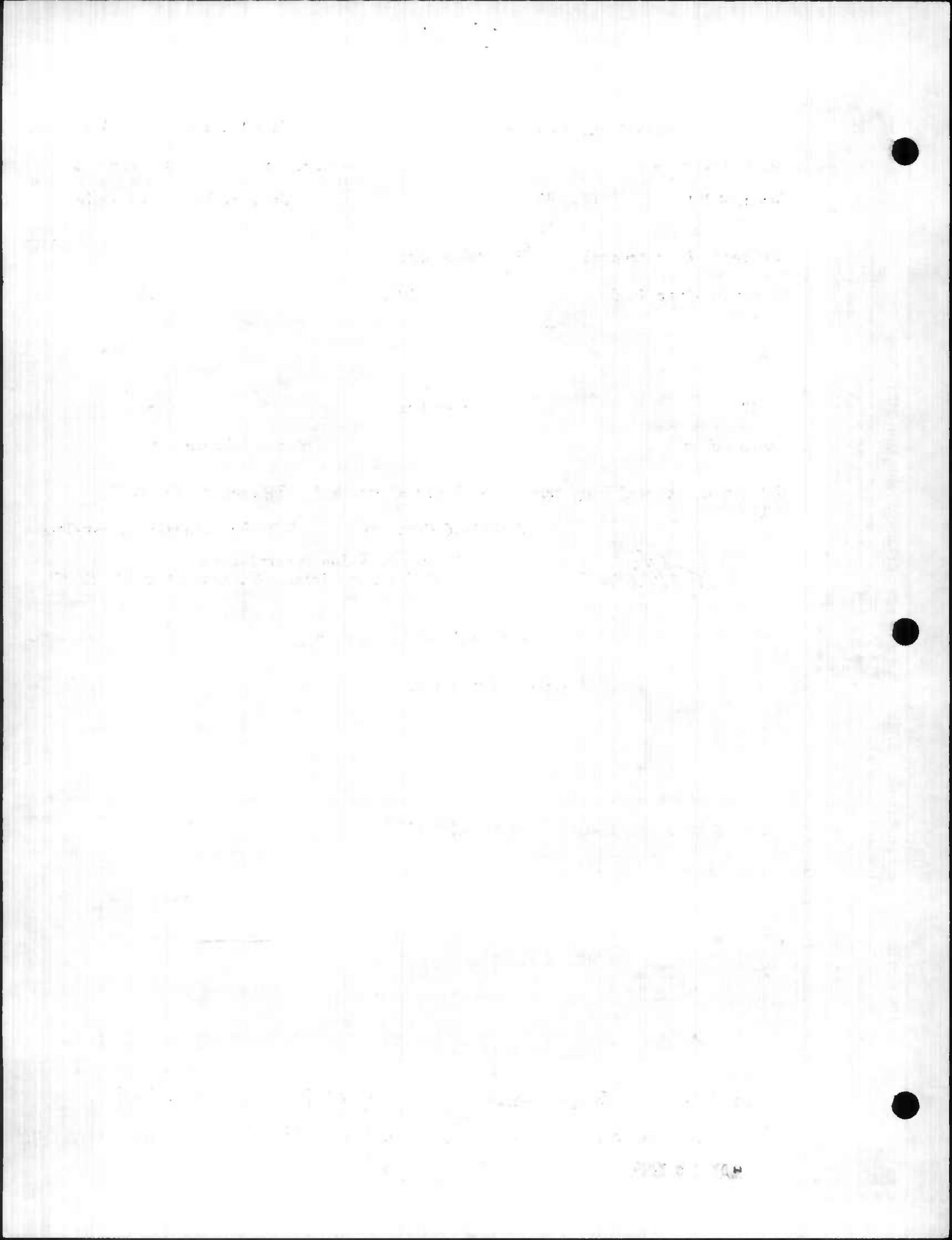
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 17973

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gertrude Rogers

2. Date of Death

May 15 1999

3. Time of Death

9:30 AM

4a. Facility Name (If not institution, give street and number)

BON SECOUR HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NONE

5. Social Security Number

217-22-3608

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

APRIL 3 1909 MARYLAND

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

NONE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2590 EDMONDSON AVENUE

10f. Zip Code

21223

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7th

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DOMESTIC

16b. Kind of Business/Industry

OUT OF THE HOME

17. Father's Name (First, Middle, Last)

BENJAMIN BROWN

18. Mother's Name (First, Middle, Maiden Surname)

GRACE G. GROSS

19a. Informant's Name/Relationship (Type, Print)

GLORIA DAVIS (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2590 EDMONDSON AVE. BALTIMORE, MD. 21223

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BROWN CEMETERY

Date

5/20/99 CHURCHTON, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Larry H. Reese

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Septic Shock Syndrome

Due to (or as a consequence of):

Ischemic Left Foot

Due to (or as a consequence of):

Coagulopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George E. Wicks Jr.

29c. License number

D41365

29d. Date signed (Month, Day, Year)

May 15, 1999

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

George E. Wicks Jr.

2000 West Baltimore St 21223

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

B. Sparrow

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

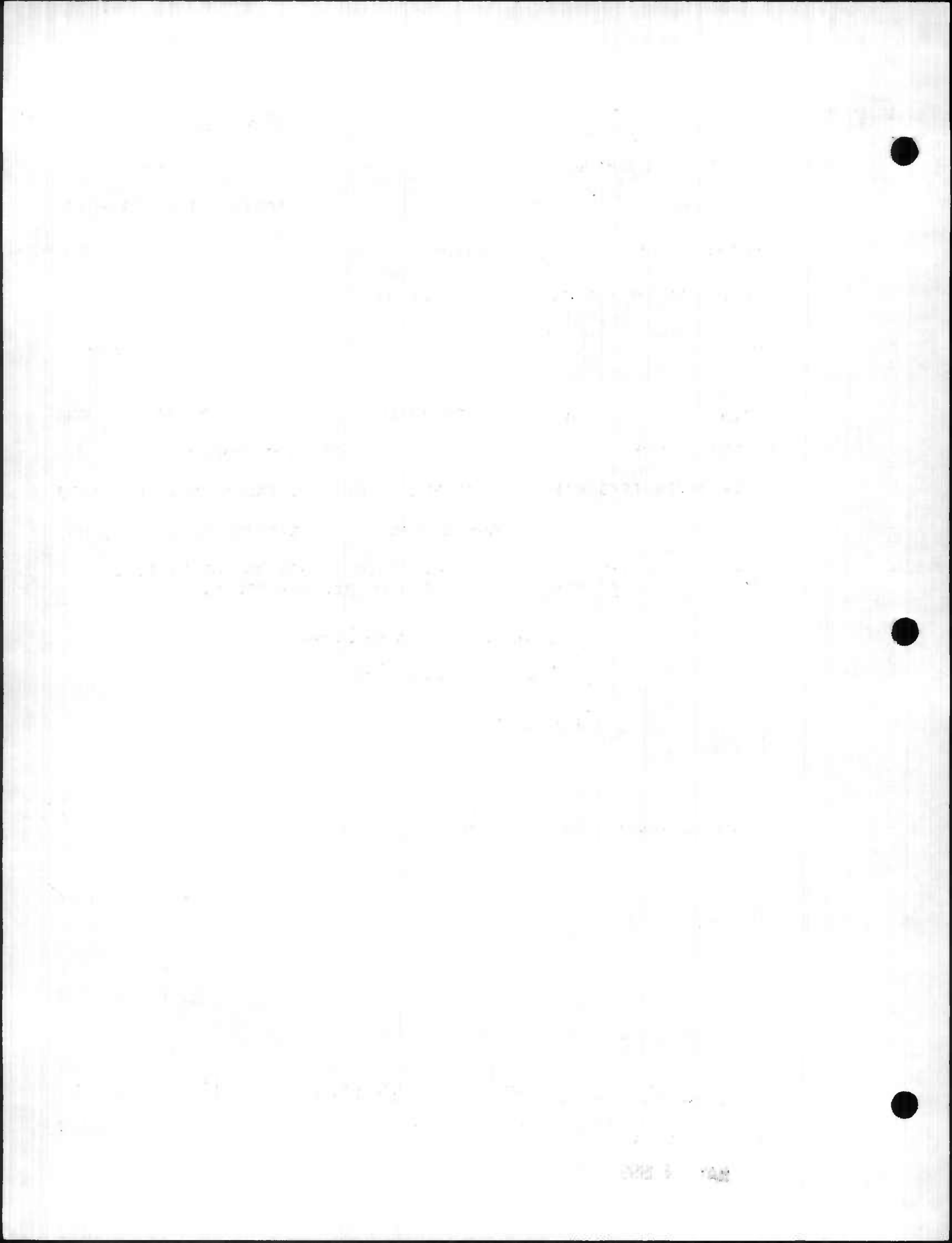
Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|--|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Agnes K. Rosenauer | | | | 2. Date of Death
Month Day Year
May 18, 1999 | | 3. Time of Death
8:29PM | |
| | 4a. Facility Name (If not institution, give street and number)
Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
214-05-0120 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
81 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
March 18, 1918 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Annapolis | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
1780 Crownsville Road | | | | 10f. Zip Code
21401 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Own Home | |
| 17. Father's Name (First, Middle, Last)
Charles Heard | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Winifred Wells | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Margaret K. Olienyk (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1046 Dockser Dr. Crownsville, MD 21032 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest Memorial Gardens | | | 20c. Location - City or Town, State
5/21/99 Annapolis, MD | |
| 21. Signature of Funeral Service Licensee
<i>Beverly M. Bolen</i> | | | | 22. Name and Address of Facility
John M. Taylor Funeral Home, Inc.
147 Duke of Gloucester St. Annapolis, MD 21401 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Respiratory Failure
Due to (or as a consequence of):

Pneumonia
Due to (or as a consequence of):

Chronic obstructive pulmonary disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
One week
One week
Chronic |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Ischemic Cardiomyopathy | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>R. Bokhari MD</i> | | | | 29c. License number
D-26594 | | 29d. Date signed (Month, Day, Year)
5/18/1999 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
R. Bokhari M.D. 64 Franklin St. Annapolis MD 21401 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 20 1999 | | 32. Registrar's Signature
<i>B. Apark</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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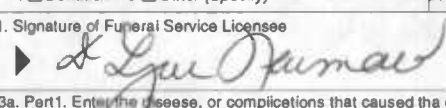
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene


Certificate of Death

Reg. No.

99 17975

| | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Lois B. Ruhe | | | | 2. Date of Death
Month Day Year
May 18, 1999 | | | | 3. Time of Death
8:29 a.m. | |
| | 4a. Facility Name (If not institution, give street and number)
Garrett County Memorial Hospital | | | | 4b. City, Town, or Location of Death
Oakland | | | | 4c. County of Death
Garrett | |
| Funeral
Director | 5. Social Security Number
160-20-7117 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (in yrs. last birthday)
71 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb 14, 1928 | | 9. Birthplace (State or Foreign Country)
Pennsylvania | |
| | Usual Residence of Decedent | | | | 10a. State
MD | | 10b. County
Garrett | | 10c. City, Town or Location
Oakland | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 10e. Street and Number
706 Seventh St. | | | | 10f. Zip Code
21550 | |
| | 10g. Citizen of What Country?
USA | | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 th College (1-4 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Sales | | | | 16b. Kind of Business/Industry
Retail | | | | 17. Father's Name (First, Middle, Last)
Morgan M. Brumbaugh | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Elsie M. Eicher | | | | 19a. Informant's Name/Relationship (Type, Print)
Mark E. Ruhe/son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
19014 Legislative Rd., Barton, MD 21521 | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Normalville Cem. | | | | 20c. Location - City or Town, State
May 22, 1999 Normalville, PA | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Newman Funeral Homes, P.A., P.O. Box 275
179 Miller St., Grantsville, MD 21536 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | |
| | a. pneumonia
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
24 hours | | | | b. aspiration due to cerebrovasc. accident
Due to (or as a consequence of): 72 hours | |
| | c.
Due to (or as a consequence of): | | | | d.
Due to (or as a consequence of): | | | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
chronic obstructive pulmonary disease | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | |
| 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | |
| 29b. Signature and title of certifier
 MD | | | | 29c. License number
D27205 | | 29d. Date signed (Month, Day, Year)
5/18/99 | | | | |
| 30. Name and address of person who completed cause of death (item 23e) (Type, Print)
Karl E. Schwalm 311 N. 4th St. Oakland, MD 21550 | | | | 31. Date filed (Month, Day, Year)
MAY 21 1999 | | | | 32. Registrar's Signature
 | | |

Baltimore, Maryland 21215-0020

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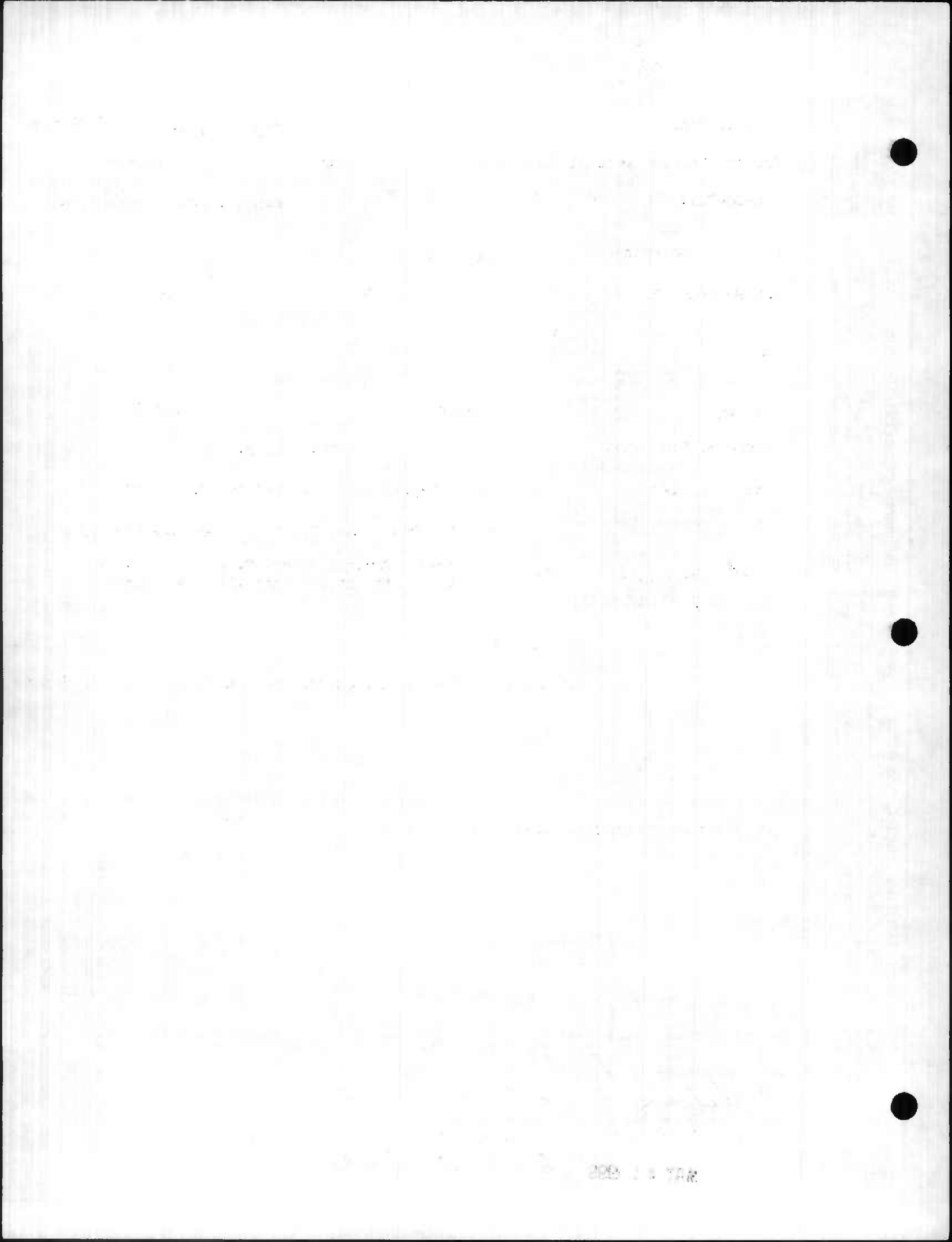
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17876

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HERBERT W. RICHTER

2. Date of Death

May 19 1999 0049

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

133-07-7193

6. Sex

M 20 F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JULY 18, 1920

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

DELAWARE

10b. County

SUSSEX

10c. City, Town or Location

MILLSBORO

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

RT#4, BOX 110

10f. Zip Code

19966

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married 20 Married
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

10 Yes 20 No
If Yes, Give Year or Dates: 1942-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HEAVY EQUIP. MECHANIC

16b. Kind of Business/Industry

CIVIL SERVICE

17. Father's Name (First, Middle, Last)

WALTER M. RICHTER

18. Mother's Name (First, Middle, Maiden Surname)

MARIE BRAN

19a. Informant's Name/Relationship (Type, Print)

JOE A. RICHTER - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

45837 FILMORE DR., GREAT MILLS, MD 20634

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State
40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ODD FELLOWS CEMETERY

Date

5-22-99

20c. Location - City or Town, State

MILFORD, DE

21. Signature of Funeral Service Licensee

George M. Short

22. Name and Address of Facility

BERRY-SHORT FUNERAL HOME
119 NW FRONT ST., MILFORD, DE 19963Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ASCAD and CABG

Due to (or as a consequence of):

6 days

c. ASCAD and Myocardial Infarction

Due to (or as a consequence of):

More than 6 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

Kidney Stones and ureteral obstruction and/or urethral

Acute renal insufficiency 6wks before death.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

26. Place of Death (Check only one)

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending investigation
20 Accident 60 Could not be determined
30 Suicide
40 Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael P. Buckner

29c. License number

02038

29d. Date signed (Month, Day, Year)

5/19/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201 Pine Bluff Road Suite 25 Salisbury MD 21801

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

Benita Sparks

State
Registrar

HERBERT RICHTER 133-07-7193

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17977

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE

EDWIN

REINARD

2. Date of Death

Month

Day

Year

Age of Decedent

1151

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

170-09-5347

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT. 23, 1907

9. Birthplace (State or Foreign Country)

NEW JERSEY

Usual Residence of Decedent

10a. State

DELAWARE

10b. County

SUSSEX

10c. City, Town or Location

SELBYVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

RT. 1 BOX 105A

10f. Zip Code

19975

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

CLAIMS ADJUSTER

16b. Kind of Business/Industry

INSURANCE

17. Father's Name (First, Middle, Last)

FRANK

REINARD

18. Mother's Name (First, Middle, Maiden Surname)

BLANCHE

BROWN

19a. Informant's Name/Relationship (Type, Print)

FLORENCE J. SCHWARTZ/SISTER-IN-LAW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RT. 1 BOX 105A, SELBYVILLE, DELAWARE 19975

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WENONAH CEMETERY

Date

5/19/99

20c. Location - City or Town, State

MANTUA TOWNSHIP, N.J.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. GASTROINTESTINAL Bleed

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 h.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- Post Surgical

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

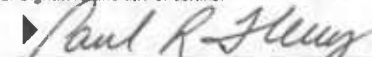
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

024872

29d. Date signed (Month, Day, Year)

5/14/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL R FLEURY 540 RIVERSIDE DR A 204 SALISBURY MD

31. Date filed (Month, Day, Year)

MAY 17 1999

32. Registrar's Signature



State Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

170-09-5347

George Reinard

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-17978

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gwendolyn R. Ross

2. Date of Death

Month Day Year
May 17, 1999

3. Time of Death

10:04 A.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

2268 Brightseat Road, Apartment 202

4b. City, Town, or Location of Death

Landover

4c. County of Death

Prince George's

5. Social Security Number

579-56-1930

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

55

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10-10-43

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD.

10b. County

Prince Georges

10c. City, Town or Location

Landover

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2268- Brightseat Road #202

10f. Zip Code

20785

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Cleveland Richardson

18. Mother's Name (First, Middle, Maiden Surname)

Minnie L. Goodwin

19a. Informant's Name/Relationship (Type, Print)

Minnie Richardson/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1417- Potomac Ave., SE Wash., DC 20003

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Riverdale Park Crematory

Date

5/19/99

20c. Location - City or Town, State

Riverdale, Md.

21. Signature of Funeral Service Licensee

Michael W. Hackert

22. Name and Address of Facility

Hackert's Funeral Chapel, Inc.
814- Upshur Street, N.W.23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. *Hypertensive and arteriosclerotic
Cardiovascular Disease*Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?*Limited*1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

J. Pestaner, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Pestaner

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

*Barbara S. [Signature]*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-696-0000.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17979

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

JOSEPH WILBUR REDMAN, JR.

2. Date of Death

Month Day Year

MAY 18, 1999

3. Time of Death

1045

4a. Facility Name (If not institution, give street and number)

107 CONVENTION CENTER DRIVE

4b. City, Town, or Location of Death

OCEAN CITY

4c. County of Death

WORCESTER

5. Social Security Number

579-20-5114

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 13, 1923

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD.

10b. County

WORCESTER

10c. City, Town or Location

OCEAN CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

107 CONVENTION CENTER DRIVE

10f. Zip Code

21842

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Lieutenant Fireman

16b. Kind of Business/Industry

D.C. Fire Department

17. Father's Name (First, Middle, Last)

JOSEPH WILBUR REDMAN, SR.

18. Mother's Name (First, Middle, Maiden Surname)

MARY ETHEL RYCE

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Anne Redman - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

107 CONVENTION CTR. DR. OCEAN CITY, MD., 21842

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

05/21/99

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gasch's Funeral Home
4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Metastatic Carcinoma Unknown Primary

2 mos

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D26278

29d. Date signed (Month, Day, Year)

5-18-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David Cornell MD 145 E. Carroll St. Solihy, MD 21801

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

B. Smith

State
Registrar

Baltimore, Maryland 21215-0020

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17980

| | | | | | | | | |
|--|--|--|---------------------------------|--|--|---|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
George Russell | | | | 2. Date of Death
Month 05 Day 18 Year 99 | | 3. Time of Death
11:50 AM | |
| | 4a. Facility Name (If not institution, give street and number)
St. Martins Little Sisters Home | | | | 4b. City, Town, or Location of Death
Catonsville | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
579-12-1767 | | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
79 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
May 1, 1920 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Annapolis | | | 10d. Inside City Limits
1 Yes 2 No | |
| 10e. Street and Number
2540 North Haven Cove | | | | 10f. Zip Code
21401 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Logistics Cataloger | | | 16b. Kind of Business/Industry
Government | |
| 17. Father's Name (First, Middle, Last)
William M. Russell | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lucy Woodburn | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Jeanne Frost Russell - Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2540 North Haven Cove, Annapolis, Maryland 21401 | | | | |
| 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery | | Date
05/22/99 | 20c. Location - City or Town, State
Brentwood, Maryland | |
| 21. Signature of Funeral Service Licenses
<i>[Signature]</i> | | | | 22. Name and Address of Facility
Gasch's Funeral Home
4739 Baltimore Avenue, Hyattsville, MD 20781 | | | | |
| 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)
a. PNEUMONIA
Due to (or as a consequence of): | | | | | | | | 2 DAYS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. ALZHEIMERS DEMENTIA
Due to (or as a consequence of): | | | | | | | | 5 YRS |
| c. Due to (or as a consequence of): | | | | | | | | |
| d. Due to (or as a consequence of): | | | | | | | | |
| Part ft. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 Yes 2 No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | | |
| 25. Was case referred to medical examiner?
1 Yes 2 No | | | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | |
| 27. Manner of Death
1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
1 Yes 2 No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29e. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29c. License number
021649 | | 29d. Date signed (Month, Day, Year)
May 19, 1999 | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SAMBANSAN BASKARAN 3455 Wilkens AVE. Baltimore MD 21229 | | | | | | | | |
| 31. Date of Death (Month, Day, Year)
MAY 21 1999 | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17981

| | | | | | |
|---|--|---|---|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Ethel Ruffin</u> | | 2. Date of Death
Month <u>May</u> Day <u>14</u> Year <u>1999</u> | | 3. Time of Death
<u>2037</u> |
| | 4a. Facility Name (If not institution, give street and number)
<u>MONTGOMERY GENERAL HOSPITAL</u> | | 4b. City, Town, or Location of Death
<u>Olney</u> | | 4c. County of Death
<u>Montgomery</u> |
| Funeral
Director | 5. Social Security Number
<u>424-50-3553</u> | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>75</u> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
<u>11-17-23</u> | | 9. Birthplace (State or Foreign Country)
<u>Alabama</u> | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
<u>Ala</u> | | 10b. County
<u>Unavailable</u> | | 10c. City, Town or Location
<u>Cuba</u> | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
<u>278 Ruffin Road</u> | | | 10f. Zip Code
<u>36907</u> | | 10g. Citizen of What Country?
<u>USA</u> |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: <u>Black</u> | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>School Worker</u> | | 16b. Kind of Business/Industry
<u>Education</u> | |
| 17. Father's Name (First, Middle, Last)
<u>Lester Curry</u> | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Lucille Casteel</u> | | |
| 19a. Informant's Name/Relationship (Type, Print)
<u>Steve Ruffin (Son)</u> | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>19308 Sherwood Greenway Gaithersburg Md</u> | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Morning Star Cemetery</u> | | 20c. Location - City or Town, State <u>5-22-99 Cuba Ala</u> | |
| 21. Signature of Funeral Service Licensee
<u>Roger J. Mason</u> | | 22. Name and Address of Facility
<u>McInnis Mortuary</u>
<u>230 Demopolis Rd Eutaw Ala 35462</u> | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. <u>Idiopathic Pulmonary Fibrosis</u> | | Years | |
| | | Due to (or as a consequence of): | | | |
| | | b. <u>Pulmonary Hypertension</u> | | Months | |
| | | Due to (or as a consequence of): | | | |
| | | c. <u>SEVERE AORTIC STENOSIS</u> | | Months | |
| | | Due to (or as a consequence of): | | | |
| | | d. | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
<u>JOSEPH A BALL</u> | | 29c. License number
<u>D53317</u> | | 29d. Date signed (Month, Day, Year)
<u>MAY 14 1999</u> | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>16220 FREDERICK ROAD Suite 213 Gaithersburg MD 20877</u> | | | | | |
| 31. Date filed (Month, Day, Year)
<u>MAY 17 1999</u> | | 32. Registrar's Signature
<u>[Signature]</u> | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17982

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
LILLIAN P ROSS | | | | 2. Date of Death
Month 5 Day 13 Year 99 | | 3. Time of Death
14:46 | |
| 4a. Facility Name (If not Institution, give street and number)
WASHINGTON ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death
TAKOMA PARK | | 4c. County of Death
MONT | |
| 5. Social Security Number
230-03-1000 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
77 Yrs. | | 8. Date of Birth (Month, Day, Year)
11/16/21 | |
| 9. Birthplace (State or Foreign Country)
WHITETOWN, NC | | 10a. State
MD | | 10b. County
PG | | 10c. City, Town or Location
HYATTSVILLE | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
3001 QUEENS CHAPEL ROAD | | 10f. Zip Code
20712 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 YEARS
College (1-4or 5+) 1 YEAR | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
COOK | | 16b. Kind of Business/Industry
CULINARY | | | |
| 17. Father's Name (First, Middle, Last)
ROBERT PRICE | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MARY WOMACK | | | |
| 19a. Informant's Name/Relationship (Type, Print)
CHAFFIN J. ROSS, JR. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7408 FINN LANE, LANHAM, MARYLAND 20706 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD NAT'L MEM PK CEM | | Date
5/20/99 | | 20c. Location - City or Town, State
LAUREL, MD. | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
JOHN T. RHINES CO., INC.
3030 12TH ST NE, DC 20017 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. suspect Pulmonary Embolism. 17 days
Due to (or as a consequence of):
b. End stage renal Disease on Dialysis. 10 days
Due to (or as a consequence of):
c. Deep Vein Thrombosis Lower Ext. 17 days.
Due to (or as a consequence of):
d. Right Heart Failure 17 days. | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Anemia
Diabetes Mellitus | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | | | 29c. License number
D41162 | | 29d. Date signed (Month, Day, Year)
May 14/99 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
D. V. Gant 1920, Doctor Drive Germantown MD 20874 | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1999 | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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|--|---|--------------------------------|---|---|---|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last) CHRISTOPHER LEE ROACH | | | | | | 2. Date of Death
Month May Day 25 Year 1999 | | 3. Time of Death
3:54 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
Memorial Hospital | | | | | | 4b. City, Town, or Location of Death
Cumberland | | 4c. County of Death
Allegany | | |
| Funeral
Director | 5. Social Security Number
216-27-0194 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
12 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct 15, 1986 | | 9. Birthplace (State or Foreign Country)
MD | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
MD | | 10b. County
Allegany | | 10c. City, Town or Location
Cumberland | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number
14208 Walter Drive | | | | 10f. Zip Code
21502 | | 10g. Citizen of What Country?
USA | | | | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Student | | | 16b. Kind of Business/Industry
Washington Middle | | | | |
| 17. Father's Name (First, Middle, Last)
Ronald E. Roach | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary A (Wilson) | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mary Anne Roach
mother | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14208 Walter Drive; Cumberland MD 21502 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Restlawn Memorial Gard | | 20c. Location - City or Town, State
5/29/ LaVale, MD | | | | | |
| 21. Signature of Funeral Service Licensee
Nicholas J. Scarpelli | | | | 22. Name and Address of Facility
Scarpelli Funeral Home P.A.
Cumberland, Maryland 21502 | | | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) e. CARDIAC ARRHYTHMIA IN ASSOCIATION WITH MYOCARDITIS
Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | Approximate Interval Between Onset and Death | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 28. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
J. Pestaner, M.D. | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
May 26, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN - 2 1999 | | | | 32. Registrar's Signature
Pinna B. Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
EDITH LOUISE SPATARO | | | | 2. Date of Death
Month MAY Day 20 Year 1999 | | 3. Time of Death
6:55 PM | |
| 4a. Facility Name (If not institution, give street and number)
SACRED HEART HOSPITAL | | | | 4b. City, Town, or Location of Death
CUMBERLAND | | 4c. County of Death
ALLEGANY | |
| 5. Social Security Number
213 22 3988 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
85 Yrs. | | 8. Date of Birth (Month, Day, Year)
APRIL 26 1914 | |
| 9. Birthplace (State or Foreign Country)
MARYLAND | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
ALLEGANY | | 10c. City, Town or Location
CUMBERLAND | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
12112 CASH VALLEY ROAD | | | | 10f. Zip Code
21502 | | 10g. Citizen of What Country?
U.S. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
OWN HOME | |
| 17. Father's Name (First, Middle, Last)
DAVID SWAUER | | | | 18. Mother's Name (First, Middle, Maiden Surname)
BEATRICE SNELSON | | | |
| 19a. Informant's Name/Relationship (Type, Print)
MARY LOUISE BURKETT / DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12112 CASH VALLEY ROAD, CUMBERLAND, MD 21502 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ST. MICHAEL'S CEMETERY | | 20c. Date
5/25/99 | | 20d. Location - City or Town, State
FROSTBURG, MD | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SOWERS FUNERAL HOME, P.A.
60 W. MAIN ST., FROSTBURG, MD 21532 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
4 days | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Acute Respiratory Distress Syndrome
Extensive Adhesion Incarcerated Ventra Hernia
Parastomal Hernia, Cholecystitis, cholelithiasis | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D25638 | | 29d. Date signed (Month, Day, Year)
MAY 22, 1999 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Saturnina Chang, M.D., Rt. 36, Frostburg Plaza, Frostburg, Maryland 21532 | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 24 1999 | | | | 32. Registrar's Signature
 | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at 502A.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17985

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Luella Ione Simpson

2. Date of Death

Month Day Year
May 21, 1999

3. Time of Death

12:30 AM

4a. Facility Name (If not institution, give street and number)

135 N. Mechanic St. Apt 506

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

217-28-8850

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 14, 1933

9. Birthplace (State or Foreign Country)

WVA

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

135 N. Mechanic St.

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

Collage (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

Cecil Carl Blackburn

18. Mother's Name (First, Middle, Maiden Surname)

Cleda L. McCauley

19a. Informant's Name/Relationship (Type, Print)

Barbara L. Soyk (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

114 Hanover St. Apt. 5 Cumberland, MD 21502

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

The Cumb. Crematory May 22, 1999 Cumberland, MD

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Merritt-Adams Funeral Home, P.A.
404 Decatur St. Cumberland, Md. 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Immediate

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic artery disease
Due to (or as a consequence of):

10 yr

c. Atherosclerosis
Due to (or as a consequence of):

10 yr

d. Hypertension
Due to (or as a consequence of):

10 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? (Check only one)

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

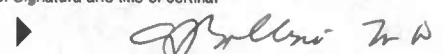
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D0017565

29d. Date signed (Month, Day, Year)

May 21, 1999

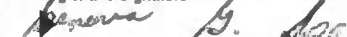
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Bollin MD 922 Mt 1 Hwy L2U21C 17 2 21502

31. Date filed (Month, Day, Year)

MAY 25 1999

32. Registrar's Signature



State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Amended # 28F mlu
Allegany County 5/25/99

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #28D PER MD G774 8-9-99 WR.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Ethan Solomon

2. Date of Death
Month Day Year
May 24 1999

3. Time of Death
3:45PM

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

319-60-6830

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

28 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct 22, 1970

9. Birthplace (State or Foreign Country)

IL

Usual Residence of Decedent

10a. State

MD

10b. County

Cecil

10c. City, Town or Location

Colora

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1079 Firetower Road

10f. Zip Code

21917

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify white

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Athletic Trainer/Teacher

16b. Kind of Business/Industry

West Nottingham Acad

17. Father's Name (First, Middle, Last)

Arthur R. Solomon

18. Mother's Name (First, Middle, Maiden Surname)

Marcia J (Crisman)

19a. Informant's Name/Relationship (Type, Print)

Marcia J. Solomon

mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1263 Hillcrest Road; Fairmont WV 26554

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cumberland Crematory

Date

5/25/ Cumberland, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility
Scarpelli Funeral Home P.A.
Cumberland, Maryland 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple trauma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 1/2 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

☒ Inpatient

☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation
☒ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

5/23/99

28b. Time of Injury

10:30AM

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

subject fell off a cliff

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Seneca Rocks

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Grant County W. Va
Pendleton County W. Va

29e. Certifier (Check only one)

☐ Certifying Physician

☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Paul Snow

Dpty Med

29c. License number

Ex D 09157

29d. Date signed (Month, Day, Year)

May 24 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Snow, M.D. 124 w 3rd st Cumb Md 21502

31. Date filed (Month, Day, Year)

MAY 25 1999

32. Registrar's Signature

Benjamin G. Spaul

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

mlu
6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17987

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dennis N. Sachs

2. Date of Death
Month Day Year

MAY 14, 1999

3. Time of Death

5:20am

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

AA COUNTY

Funeral
Director

5. Social Security Number

543-46-3544

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

56

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Dec 28, 1942

9. Birthplace (State or Foreign Country)

Oregon

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

18 Boone Trail

10f. Zip Code

21146

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married

☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collega (1-4or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Economist

16b. Kind of Business/Industry

Research

17. Father's Name (First, Middle, Last)

Milton S. Sachs

18. Mother's Name (First, Middle, Maiden Surname)

Billie A. (Unknown)

19a. Informant's Name/Relationship (Type, Print)

Marianne Sachs / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18 Boone Trail, Severna Park, MD 21146

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hillcrest Memorial Gardens

Date

MAY 16 1999

20c. Location - City or Town, State

Annapolis, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy., Severna Park, MD 21146

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

RENAL FAILURE

a. Due to (or as a consequence of):

ACUTE MYOCARDIAL INFARCTION

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation

☐ Accident ☐ Could not be determined

☐ Suicida ☐ Homicida

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician

29b. Signature and title of certifier

[Signature] MD

29c. License number

D43977

29d. Date signed (Month, Day, Year)

May 14 1999

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

NORTH ARUNDEL HOSPITAL 301 HOSPITAL DR GLEN BURNIE MD 21061

31. Date filed (Month, Day, Year)

MAY 17 1999

32. Registrar's Signature

[Signature] B. Ap... MD

State
Registrar

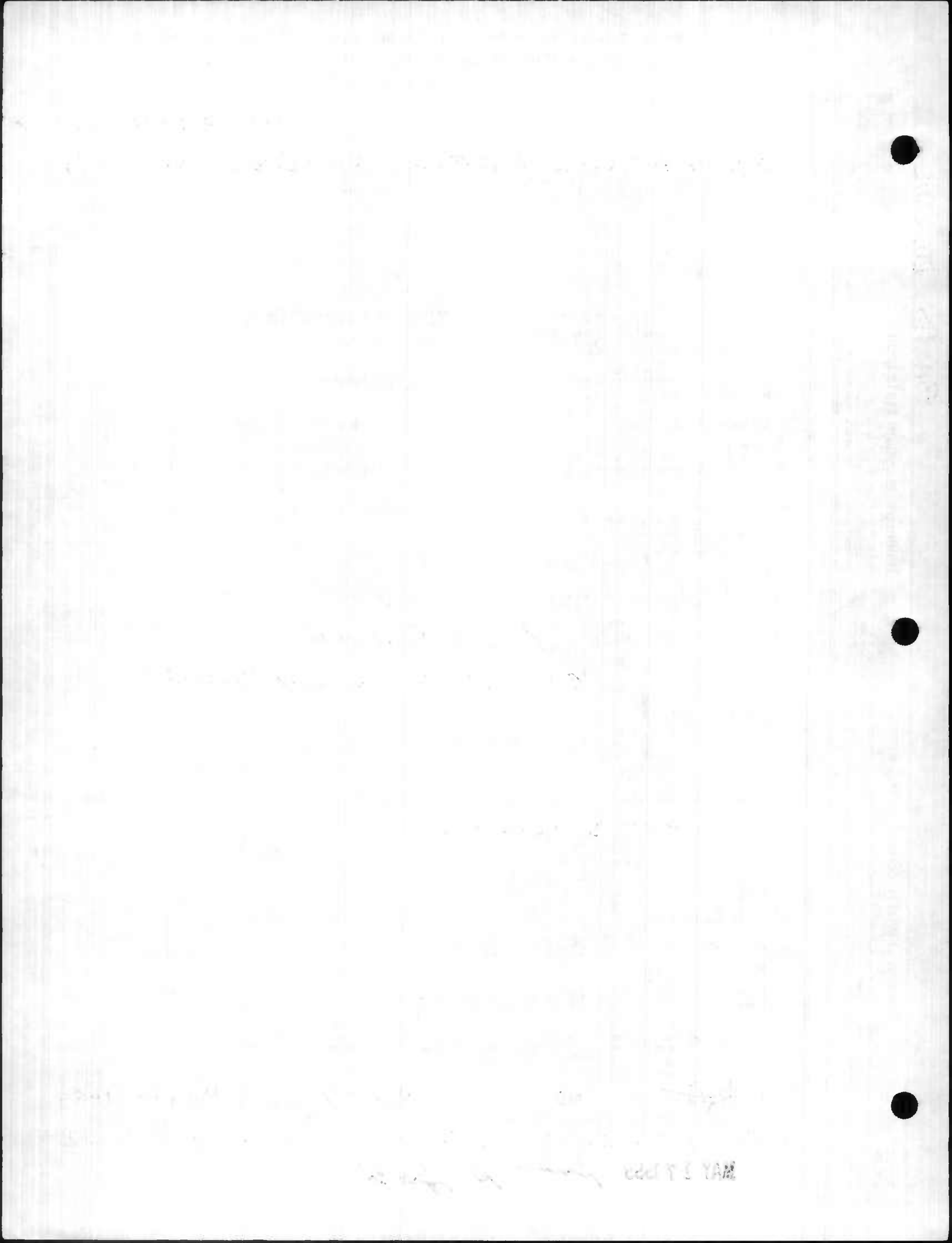
Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17988

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Christine Schmidt

2. Date of Death

Month

Day

Year

05

13

99

3. Time of Death

8:30 PM

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare

4b. City, Town, or Location of Death

Severna Park

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

058-07-6572

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

8. Date of Birth (Month, Day, Year)

Feb 13, 1915

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

24 Truckhouse Road

10f. Zip Code

21146

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Business Manager

16b. Kind of Business/Industry

Doctor's Office

17. Father's Name (First, Middle, Last)

John Gimpel

18. Mother's Name (First, Middle, Maiden Surname)

Martha Haas

19a. Informant's Name/Relationship (Type, Print)

Robert Schmidt / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

936 Placid Court, Arnold, MD 21012

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

May 17 1999

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy., Severna Park, MD 21146

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dementia - Alzheimer's type

Due to (or as a consequence of):

> 2 yrs

b. Rectovaginal Fistula

Due to (or as a consequence of):

5 days

c. Hypotension

Due to (or as a consequence of):

1 day

d. Hypothyroidism

> 1 year

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John F. Loomer, M.D. Attending Physician

29c. License number

D52728

29d. Date signed (Month, Day, Year)

05/14/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John F. Loomer, M.D. 1454 Baltimore & Annapolis Blvd. Arnold, MD 21012

31. Date filed (Month, Day, Year)

MAY 17 1999

32. Registrar's Signature

Barbara G. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

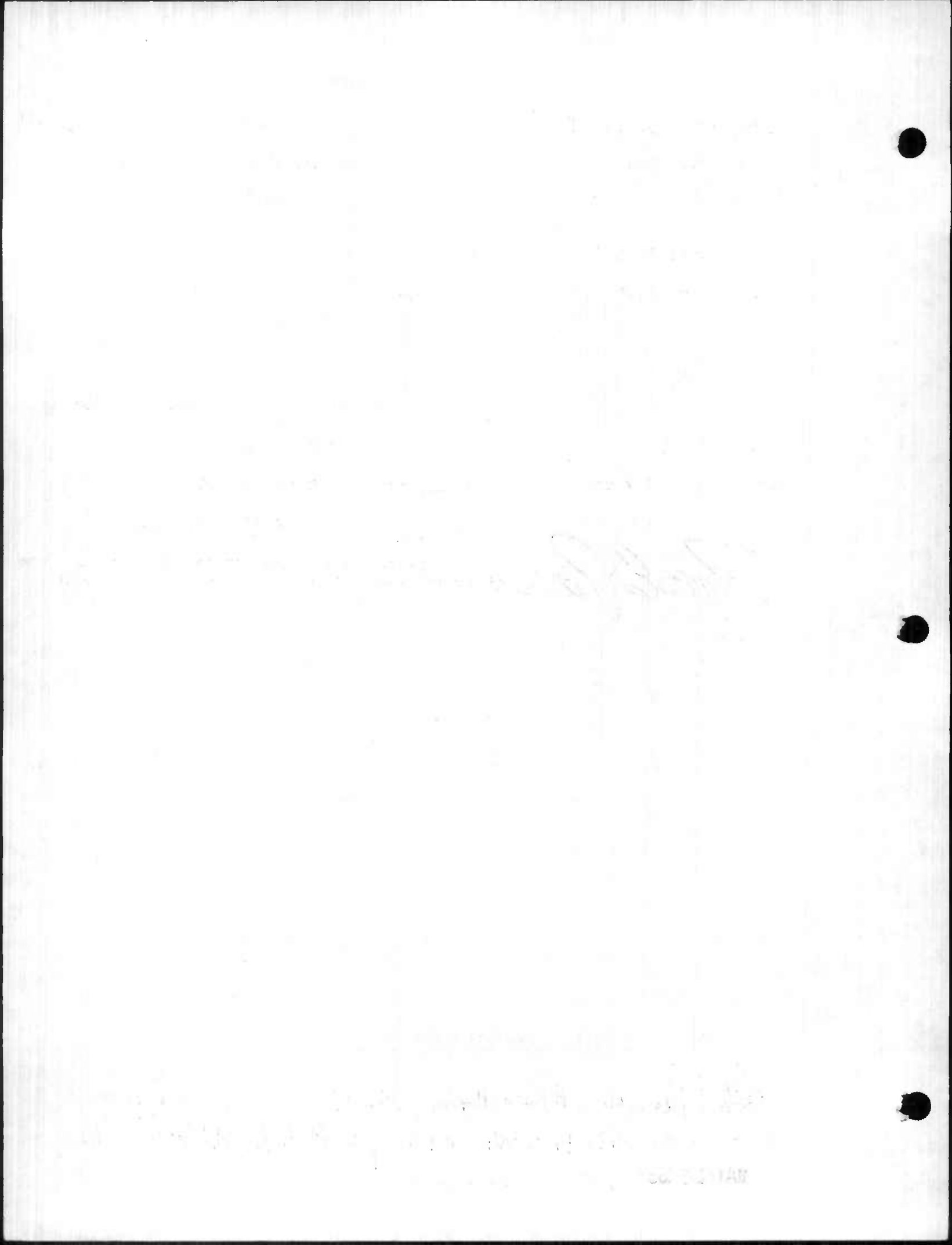
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 17989

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|---|---|---|--|---|----|-------------------------------|---|----------------------------------|--|--|----|---|----------------|----------------------------------|--|--|--|----|--|--|----------------------------------|--|--|----|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
NORMAN STANSBURY | | | | | | 2. Date of Death
Month Day Year
MAY 13 1999 | | | 3. Time of Death
6:20 am | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
ANNE ARUNDEL MEDICAL CENTER | | | | | | 4b. City, Town, or Location of Death
ANNAPOLIS | | | 4c. County of Death
ANNE ARUNDEL | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
217-38-5238 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
58 Yrs. | | 8. Date of Birth (Month, Day, Year)
MAY 16 1940 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
ANNAPOLIS | | | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | |
| 10e. Street and Number
30 G. AMBERSTONE COURT | | | | | | 10f. Zip Code
21403 | | 10g. Citizen of What Country?
US | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11th College (1-4or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MAINTENANCE | | | 16b. Kind of Business/Industry
ANNAPOLIS NURSING & REHABILITATION | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
NORMAN STANSBURY | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MINNIE JOHNSON | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
ANN STANSBURY (WIFE) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
30 G. AMBERSTONE CT. ANNAPOLIS, MD. 21403 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
METRO CREMATORY | | Date
5/14/99 | | 20c. Location - City or Town, State
BALTIMORE, MD. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
<i>Larry H. Reese</i> | | | | | | 22. Name and Address of Facility
WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Aspiration Pneumonitis</td> <td>Approximate Interval Between Onset and Death
24 hours</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td>Multiple Cerebral Vascular Accidents</td> <td>3 years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>c.</td> <td></td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> <td></td> </tr> </table> | | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. | Aspiration Pneumonitis | Approximate Interval Between Onset and Death
24 hours | Due to (or as a consequence of): | | | b. | Multiple Cerebral Vascular Accidents | 3 years | Due to (or as a consequence of): | | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | c. | | | Due to (or as a consequence of): | | | d. | | | |
| Immediate Cause (Final disease or condition resulting in death) | a. | Aspiration Pneumonitis | Approximate Interval Between Onset and Death
24 hours | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | b. | Multiple Cerebral Vascular Accidents | 3 years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | c. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Wayne Bierbaum, MD</i> | | | | | | 29c. License number
D38563 | | 29d. Date signed (Month, Day, Year)
May 13, 1999 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wayne Bierbaum, MD 134 Anensville RD West River MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1999 | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

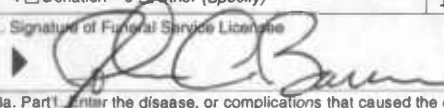
State of Maryland / Department of Health and Mental Hygiene

99 17990

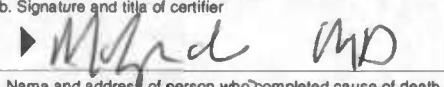
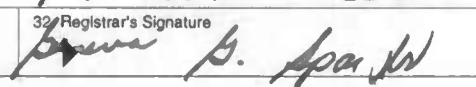
AMEND# 10G;CMH AACO HEALTH DEPT. 5/19/99

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Jozsef Szucs | | | | 2. Date of Death
Month 5 Day 10 Year 99 | | 3. Time of Death
1600 | |
| | 4a. Facility Name (If not institution, give street and number)
Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
218-92-5875 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
57 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sept 26, 1941 | 9. Birthplace (State or Foreign Country)
Hungary |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Severn | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
7903 South Cartier Court | | | | 10f. Zip Code
21144 | | 10g. Citizen of What Country?
USA Germany | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Self employed | | | 16b. Kind of Business/Industry
Television Repair | |
| 17. Father's Name (First, Middle, Last)
Jozsef Szucs | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Jolan Banok | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Rosemarie W. Szucs/wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7903 South Cartier Court, Severn, MD 21144 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakemont Memorial Gardens | | 20c. Location - City or Town, State
May 15 1999 Davidsonville, MD | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy., Severna Park, MD 21146 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Sepsis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
SBO
Pancreatic Carcinoma | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
UGI Bleed | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
 MD | | 29c. License number
D45096 | | 29d. Date signed (Month, Day, Year)
5/19/99 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
M. Sheila McBride, 180 Admiral Cochrane Dr, Annapolis, MD 21401 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1999 | | 32. Registrar's Signature
 | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17991

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lyle Harrison Sharpless

2. Date of Death

May 14 1999

3. Time of Death

10:40 pm

4a. Facility Name (If not institution, give street and number)

131 Highland Dr.

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

Funeral
Director

5. Social Security Number

213-01-4054

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov 18 1915

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

Garrett

10c. City, Town or Location

Oakland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

131 Highland Dr.

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

-7-

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Coal Miner

16b. Kind of Business/Industry

Coal

17. Father's Name (First, Middle, Last)

Berkley Sharpless

18. Mother's Name (First, Middle, Maiden Surname)

Lilly Paugh

19a. Informant's Name/Relationship (Type, Print)

Victoria E. Sharpless

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

131 Highland Dr. Oakland, Md 21550

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Sharpless Cemetery

Date

May 17 '99

20c. Location - City or Town, State

Mt Zion, Md

21. Signature of Funeral Service Licensee

David A. Burdock

22. Name and Address of Facility

David A. Burdock Funeral Home

710 Church St. Kitzmiller, Md 21538

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Parkinsons

Approximate
Interval Between
Onset and Death

Years

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of injury

(Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Paul D. Smith MD

29c. License number

H26154

29d. Date signed (Month, Day, Year)

May 16 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

69 Wolf Acres Dr. Oakland, Md 21550

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

B. Smith

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

8

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Julia Elizabeth Skidmore

2. Date of Death

May 10, 1999

3. Time of Death

6:45 p.m.

4a. Facility Name (If not institution, give street and number)

Magnolia Gardens

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

214-32-2891

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

98

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 2, 1901

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8200 Goodluck Road

10f. Zip Code

20801

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1 year

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Assistant Postmaster

16b. Kind of Business/Industry

US Postal Service

17. Father's Name (First, Middle, Last)

William James Friend

18. Mother's Name (First, Middle, Maiden Surname)

Loudica (Friend)

19a. Informant's Name/Relationship (Type, Print)

Howard James Skidmore/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12621 Safety Turn, Bowie, MD 20715

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Addison Cemetery, May 13, 1999

Date

20c. Location - City or Town, State

Addison, PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Newman Funeral Homes, P.A., P.O. Box 275
179 Miller St., Grantsville, MD 2153623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Sepsis
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

One week

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb.
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Ratna Foucha

29c. License number

D43446

29d. Date signed (Month, Day, Year)

5/11/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROINTAN FARAHIFAR MD. 4000 Mitchellville road B216 Bowie MD 20716

31. Date filed (Month, Day, Year)

MAY 12 1999

32. Registrar's Signature

Beverly A. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17993

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GLORIA

REED

STERLING

2. Date of Death

Month

Day

Year

May 17, 1999

3. Time of Death

0245

Funeral
Director

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

221-44-0240

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

43

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAR 20, 1956

9. Birthplace (State or Foreign Country)

DELAWARE

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WICOMICO

10c. City, Town or Location

HEBRON

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

27004 CROOKED OAK LANE

10f. Zip Code

21830

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ADMINISTRATIVE ASSISTANT

16b. Kind of Business/Industry

PASTORAL CARE

17. Father's Name (First, Middle, Last)

WILMER C. REED

18. Mother's Name (First, Middle, Maiden Surname)

KATHERINE ANDERSON

19a. Informant's Name/Relationship (Type, Print)

WILLIAM T. STERLING, JR./HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

27004 CROOKED OAK LANE, HEBRON, MD 21830

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CAREY'S CEMETERY

Date

5/20

20c. Location - City or Town, State

MILLSBORO, DELAWARE

21. Signature of Funeral Service Licensee

Richard T. Watson

22. Name and Address of Facility

WATSON FUNERAL HOME, INC.

211 WASHINGTON ST., MILLSBORO, DE 19966

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Malignant lymphoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 mo.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

Joseph A. Grasso MD

29c. License number

020507

29d. Date signed (Month, Day, Year)

5/17/99

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Joseph A. Grasso 145 E. CARROLL ST SALISBURY MD

31. Date filed (Month, Day, Year)

MAY 18 1999

32. Registrar's Signature

Geneva S Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 17996

| | | | | | | | | |
|---|--|---|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
George Lewis Swanson | | | | 2. Date of Death
Month May Day 17 Year 1999 | | 3. Time of Death
4:50 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Anne Arundel General Hospital | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
216-38-5265 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
70 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sept. 2, 1928 | 9. Birthplace (State or Foreign Country)
Wash. D.C. |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Prince Georges | | 10c. City, Town or Location
Upper Marlboro | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
16315 Swanson Road | | | | 10f. Zip Code
20774 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Farming | | | 16b. Kind of Business/Industry
Farm | |
| 17. Father's Name (First, Middle, Last)
Robert B. Swanson | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Jessie Millicent Sisson | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Carolyn Swanson/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16315 Swanson Road Upper Marlboro Md. 20774 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | Date
5-20-99 | | 20c. Location - City or Town, State
Alexandria Virginia | | |
| 21. Signature of Funeral Service Licensee
Shannon W. Ramirez
Shannon W. Ramirez M00798 | | | | 22. Name and Address of Facility
Beall Funeral Home
6512 N.W. Crain Highway Bowie, Md. 20715 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

RESPIRATORY FAILURE
Due to (or as a consequence of):
PNEUMONIA
Due to (or as a consequence of):
HYPOXEMIA
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
METASTATIC PROSTATE CANCER
CARDIOMYOPATHY
CONGESTIVE HEART FAILURE | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Chad M.D. | | 29c. License number
MD31130 | | 29d. Date signed (Month, Day, Year)
5/17/99 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CHRISTOPHER PHILLIPS, MD
64 FRANKLIN STREET, ANNAPOLIS, MD | | | | | | | | 21002 |
| 31. Date filed (Month, Day, Year)
MAY 19 1999 | | Registrar's Signature
B. Smith | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

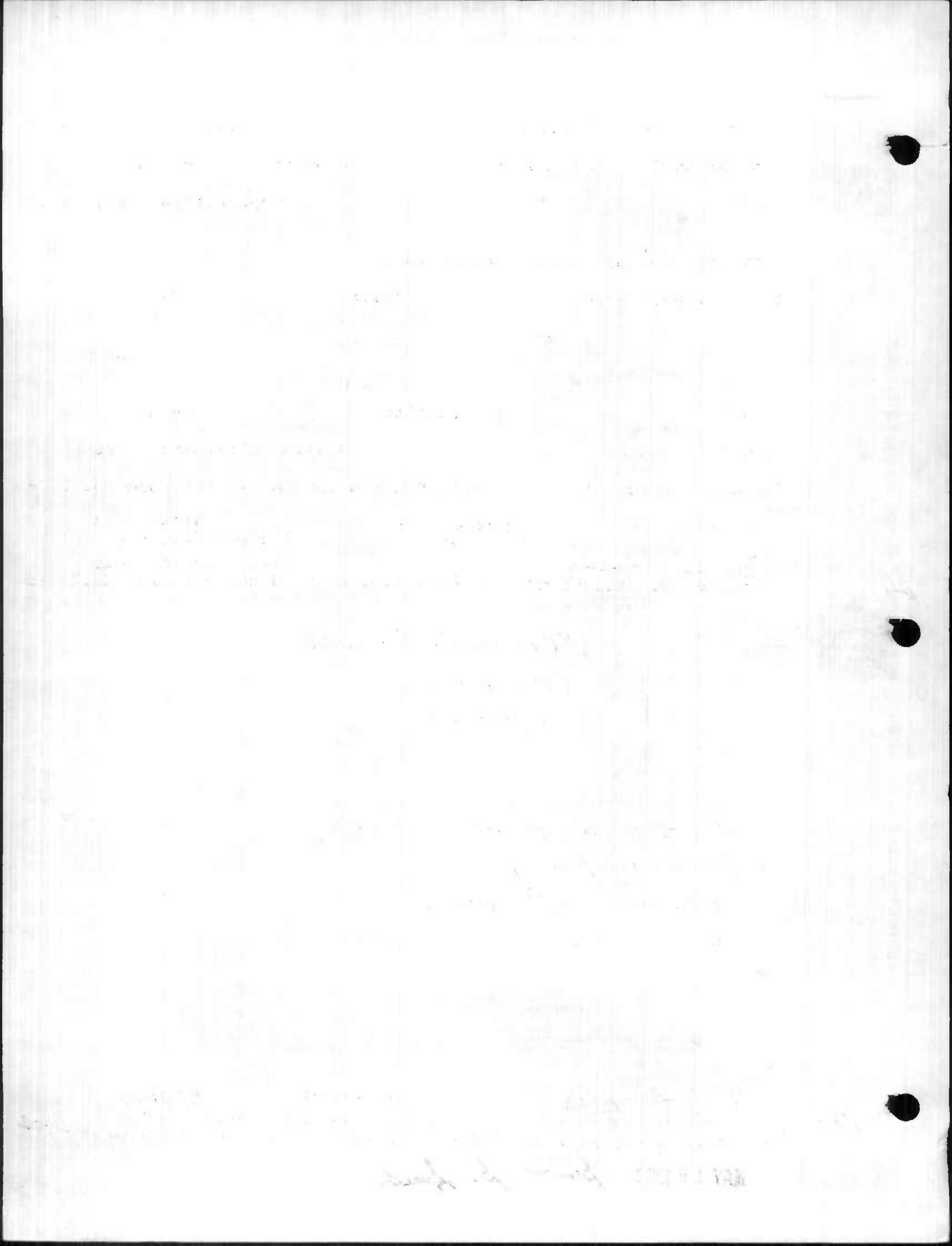
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

15



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

89-17995

Amend #25. Per M.E. PGC 5-20-99 cr

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Herbert Steele | | | | 2. Date of Death
Month Day Year
May 17 1999 | | 3. Time of Death
9:40AM | |
| | 4a. Facility Name (If not institution, give street and number)
Washington Adventist Hospital | | | | 4b. City, Town, or Location of Death
Takoma Park | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
245-07-2861 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
79 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
May 1, 1920 | |
| | 9. Birthplace (State or Foreign Country)
North Carolina | | | | | | | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State
District of Columbia | | 10b. County
Washington | | 10c. City, Town or Location
Washington | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
401 K St., N.W. #202 N | | | | 10f. Zip Code
20001 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: African American | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Head Cook | | | 16b. Kind of Business/Industry
Private | |
| 17. Father's Name (First, Middle, Last)
Unknown | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lula Steele | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Gwen Ewing - Daughter | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4900 Bayberry Ct., Upper Marlboro, MD 20772 | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln Memorial Cem. | | 20c. Location - City or Town, State
Suitland, MD | | |
| 21. Signature of Funeral Service Licensee
John T. Stewart III | | | | 22. Name and Address of Facility
Stewart Funeral Home
4001 Benning Rd., N.E. Wash., D.C. 20019 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. Massive Aspiration
Due to (or as a consequence of):
b. Upper gastrointestinal tract hemorrhage
Due to (or as a consequence of):
c. Bacterial pneumonia
Due to (or as a consequence of):
d. 5/20/99 | | | | | | | | Approximate Interval Between Onset and Death
hours |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Senile Dementia
Fracture Right Humerus
Diabetes Mellitus Type II | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
Paul A. DeVore | | 29c. License number
D01852 | | 29d. Date signed (Month, Day, Year)
May 17 1999 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PAUL A. DEVORE, MD 4203 Queensbury Rd Hyattsville MD 20783 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 20 1999 | | | | 32. Registrar's Signature
B. Smith | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

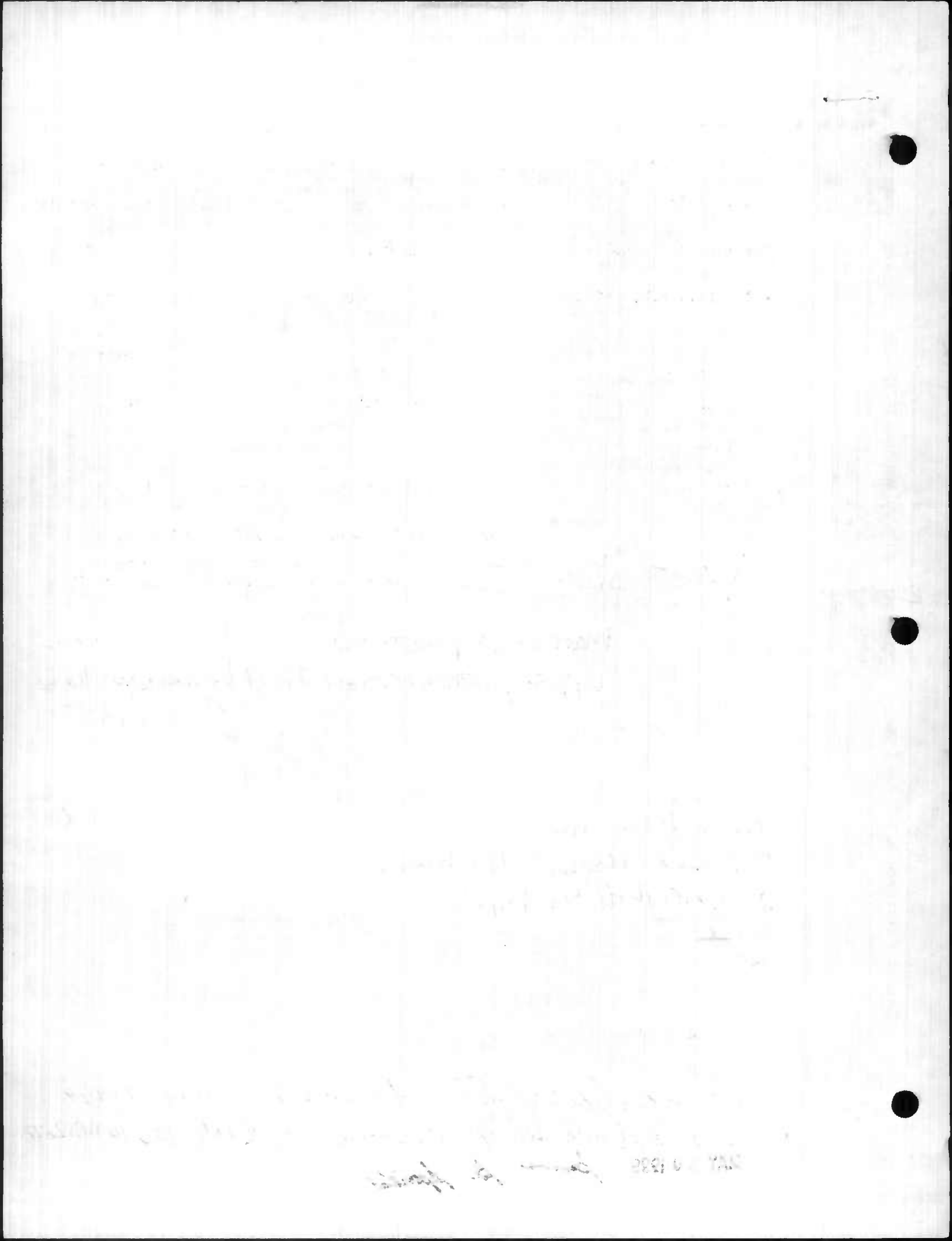
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar



99-2721-033

MICHELLE
SMITH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17996

| | | | | | | | | | |
|--|---|--|---|--|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MICHELLE SMITH | | | | 2. Date of Death
Month: MAY Day: 11 Year: 1999 | | 3. Time of Death
8:16A.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
PRINCE GEORGES HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
CHEVERLY | | 4c. County of Death
PRINCE GEORGES | | |
| Funeral
Director | 5. Social Security Number
577-15-0722 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
13 Yrs. | | 8. Date of Birth (Month, Day, Year)
1-29-1986 | | |
| | 9. Birthplace (State or Foreign Country)
WASHINGTON, DC | | 10a. State
MD | | 10b. County
PRINCE GEORGES | | 10c. City, Town or Location
LANDOVER | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| 10e. Street and Number
2506 PINEBROOK AVE., #2 | | | | 10f. Zip Code
20785 | | 10g. Citizen of What Country?
U.S.A. | | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 7th College (1-4 or 5+): | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
STUDENT | | | 16b. Kind of Business/Industry
N/A | | |
| 17. Father's Name (First, Middle, Last)
MICHAEL KEVIN SMITH | | | | 18. Mother's Name (First, Middle, Maiden Surname)
LISA WILLIAMS | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
LISA WILLIAMS - MOTHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2506 PINEBROOK AVE., #2 LANDOVER, MD 20785 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
FOREST HILLS MEM. GARD. 18-99 | | | 20c. Location - City or Town, State
CLINTON, MARYLAND | | | |
| 21. Signature of Funeral Service Licensee
<i>B. C. Taylor</i> | | | | 22. Name and Address of Facility
TAYLOR'S FUNERAL HOME
1722 NORTH CAPITOL ST., NW WASH. DC 20001 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Seizure Disorder
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Dennis J. Chute</i> | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
MAY 12, 1999 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 17 1999 | | | 32. Registrar's Signature
<i>B. Smith</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

2

Handwritten signature

8281 1 1411

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy M. Sanalistro

2. Date of Death

Month Day Year
5 12 99

3. Time of Death

2 PM

4a. Facility Name (If not institution, give street and number)

Doctor's Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

577-34-6864

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 23, 1926

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Riverdale

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6705 Furman Parkway

10f. Zip Code

20737

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teller

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

William Williams

18. Mother's Name (First, Middle, Maiden Surname)

Hattie Mae Williams

19a. Informant's Name/Relationship (Type, Print)

Mary V. Fowler - Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

824 Hilltop Terrace, S.E., Washington, DC 20019

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

05/22/99

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Henry S. Fowler

22. Name and Address of Facility

Gasch's Funeral Home
4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

respiratory failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hour

b.

metastatic cancer, lung

Due to (or as a consequence of):

2 mos

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide

5 ☐ Pending investigation
6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Martin D. Weitz

29c. License number

523743

29d. Date signed (Month, Day, Year)

5-13-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARTIN D. WEITZ 7525 Greenway Ct Dr Greenbelt MD 20776

31. Date filed (Month, Day, Year)

MAY 17 1999

32. Registrar's Signature

Maria B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

LAVERN KEONTAGE SMITH

ITEMS: #23 PART I, 27, 28A-F PER MEO G773 6-30-99 WR.

Certificate of Death

Reg. No.

99 17998

| | | | | | | | | |
|--|--|--|---|--------------------------------|--|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
KEONTAYE LAVERNE SMITH | | | | 2. Date of Death
Month Day Year
MAY 23, 1999 | | 3. Time of Death
2150 PM | |
| | 4a. Facility Name (If not institution, give street and number)
3322 DODGE PARK ROAD #103 | | | | 4b. City, Town, or Location of Death
LANDOVER | | 4c. County of Death
PRINCE GEORGES | |
| Funeral
Director | 5. Social Security Number
577-29-4539 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
2 Yrs. | 8. Under 1 Year
Months Days | 9. Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
FEB 1, 1997 | | 9. Birthplace (State or Foreign Country)
WASHINGTON DC |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
prince georges | 10c. City, Town or Location
LANDOVER | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number
3322 DODGE PARK RD APT 103 | | | 10f. Zip Code
20785 | | 10g. Citizen of What Country?
UNITED STATES | | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) n/a College (1-4 or 5+) n/a | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
N/A | | 16b. Kind of Business/Industry
n/a | | | |
| | 17. Father's Name (First, Middle, Last)
FRANK HOWARD | | | | 18. Mother's Name (First, Middle, Maiden Surname)
TAMARA SMITH | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
TAMARA SMITH / MOTHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3322 DODGE PARK RD #103 LANDOVER, MD 20785 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MOUNT OLIVET CEMETERY | | 20c. Date
5-29-99 | | 20d. Location - City or Town, State
WASHINGTON DC | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
ALEXANDER S. POPE FUNERAL HOME
2617 PENN. AVE S.E. WASHINGTON DC 20020 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

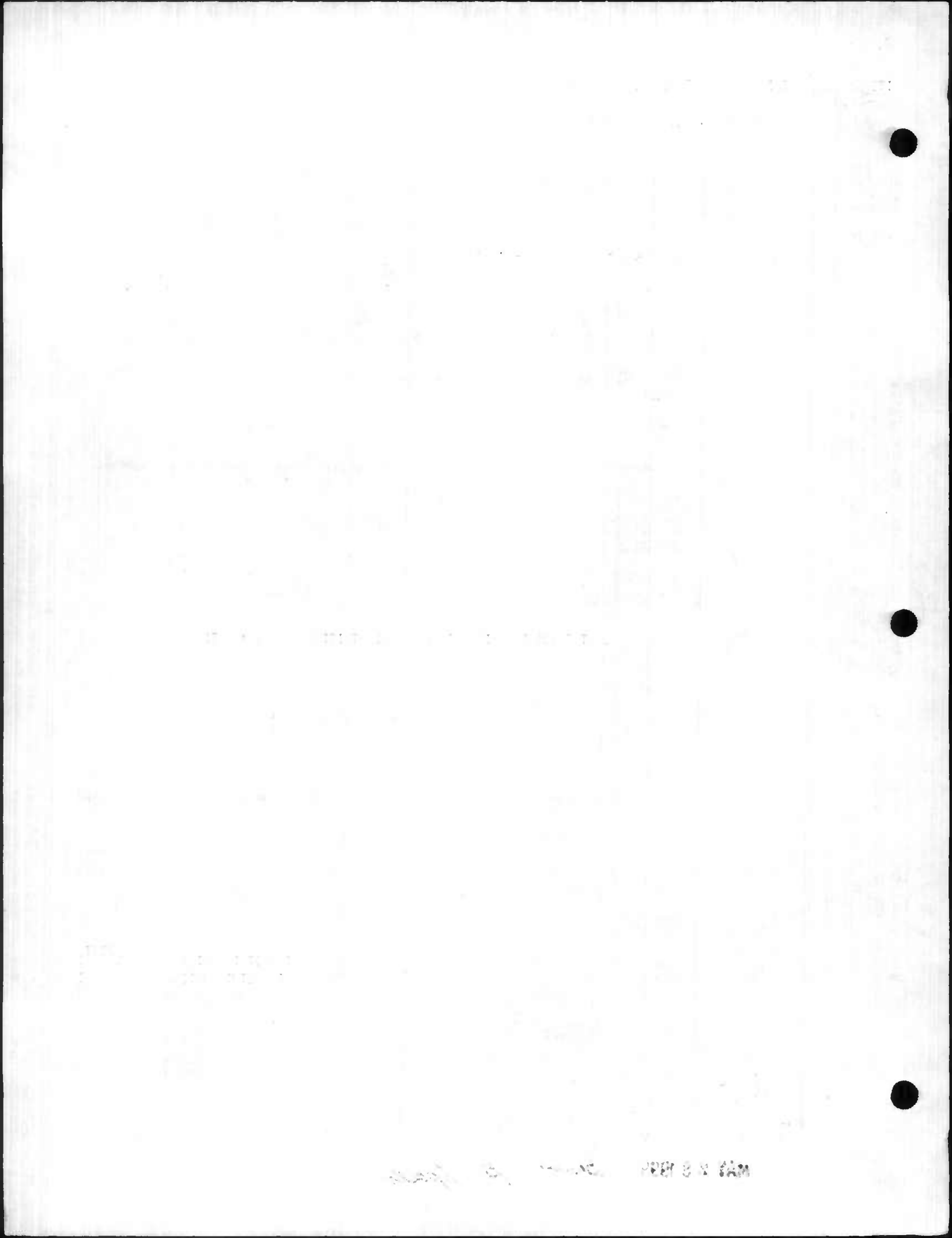
Immediate Cause (Final disease or condition resulting in death)
a. BLUNT FORCE INJURIES OF HEAD, MALNUTRITION AND DEHYDRATION
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
UNKNOWN | | 28b. Time of Injury
UNKNOWN M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
HOME | | 28d. Describe how injury occurred
IMPACT INJURIES, WAS MALNOURISHED AND DEHYDRATED | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
3322 DODGE PARK RD.
LANDOVER, MD | | | | | | | |
| State
Registrar | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
<i>[Signature]</i> | | | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
MAY 24, 1999 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. LARON WARE, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 26 1999 | | | | | | | | |
| 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 17999

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)
RALPH DENNIS SANTORA | | | | 2. Date of Death
Month MAY Day 22 Year 1999 | | 3. Time of Death
4:58 AM | |
| 4a. Facility Name (If not institution, give street and number)
CIVISTA MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
LAPLATA | | 4c. County of Death
CHARLES | |
| 5. Social Security Number
152-30-2938 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
57 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Dec. 9, 1941 | |
| 9. Birthplace (State or Foreign Country)
New Jersey | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Charles | | 10c. City, Town or Location
White Plains | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number
8489 Cardinal Lane | | | | 10f. Zip Code
20695 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1964-73 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Manager | | 16b. Kind of Business/Industry
Federal Government | |
| 17. Father's Name (First, Middle, Last)
John Mario Santora | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Antoinette Pennacchio | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Alberta H. Santora | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8489 Cardinal Lane, White Plains, MD 20695 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery | | 20c. Location - City or Town, State
5-25-99 Suitland, MD | | 20d. Date | |
| 21. Signature of Funeral Service Licensee
John P. Knisley 001164 | | | | 22. Name and Address of Facility
Huntt Funeral Home, Inc.,
P. O. Box 156, Waldorf, MD 20604-0156 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
CANCER OF LUNG

Due to (or as a consequence of):
METASTATIC

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death
Yr | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier
Krishan M. Mathur | | | | 29c. License number
D-28352 | | 29d. Date signed (Month, Day, Year)
5/22/99 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KRISHAN M. MATHUR CAMBRIDGE PROF. CTR. SUITE 102 WALDORF, MD 20602 | | | | | | | |
| 31. Date filed (Month, Day, Year)
MAY 25 1999 | | | | 32. Registrar's Signature
B. Spence | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Ralph Santora
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
IRENE C. SAVOY | | | | 2. Date of Death
Month Day Year
MAY 18 1999 | | 3. Time of Death
10:55PM | |
| | 4a. Facility Name (If not institution, give street and number)
2285 PORT TOBACCO ROAD | | | | 4b. City, Town, or Location of Death
NANJEMOY | | 4c. County of Death
CHARLES | |
| Funeral
Director | 5. Social Security Number
220-34-8439 | | 6. Sex
1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
85 | | 8. Date of Birth (Month, Day, Year)
January 26, 1914 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Charles | | 10c. City, Town or Location
Nanjemoy | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
2285 Port Tobacco Road | | 10f. Zip Code
20662 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Her /Others Home | | 17. Father's Name (First, Middle, Last)
Elmer Carroll, Sr. | |
| | 18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 18. Mother's Name (First, Middle, Maiden Surname)
Julia | | 19a. Informant's Name/Relationship (Type, Print)
Terawana R. Keys Granddaughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4875 Pisgah Marbury Rd., Marbury, Md. 20658 | |
| Physician
/Medical
Examiner | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Grove Baptist Church | | 20c. Location - City or Town, State
Nanjemoy, Maryland | | 21. Signature of Funeral Service Licensee
 | |
| | 22. Name and Address of Facility
Williams Funeral Home, P.A.
4270 Hawthorne Rd., Indian Head, Md. 20640 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

CEREBRAL VASCULAR ACCIDENT | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 23c. Approximate Interval Between Onset and Death | |
| Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020 | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
May 22, 1999 | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | |
| | 29b. Signature and title of certifier
 | | 29c. License number
008370 | | 29d. Date signed (Month, Day, Year)
5/19/99 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Paul E. Pritchett, Sr., MD. 118 LaGrange Ave., LaPlata, Md. 20646 | |
| State Registrar | 31. Date filed (Month, Day, Year)
MAY 24 1999 | | 32. Registrar's Signature
 | | | | | |

